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# Manitoba Medical Review



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**Vol. 25**

**OCTOBER, 1945**

**No. 10**

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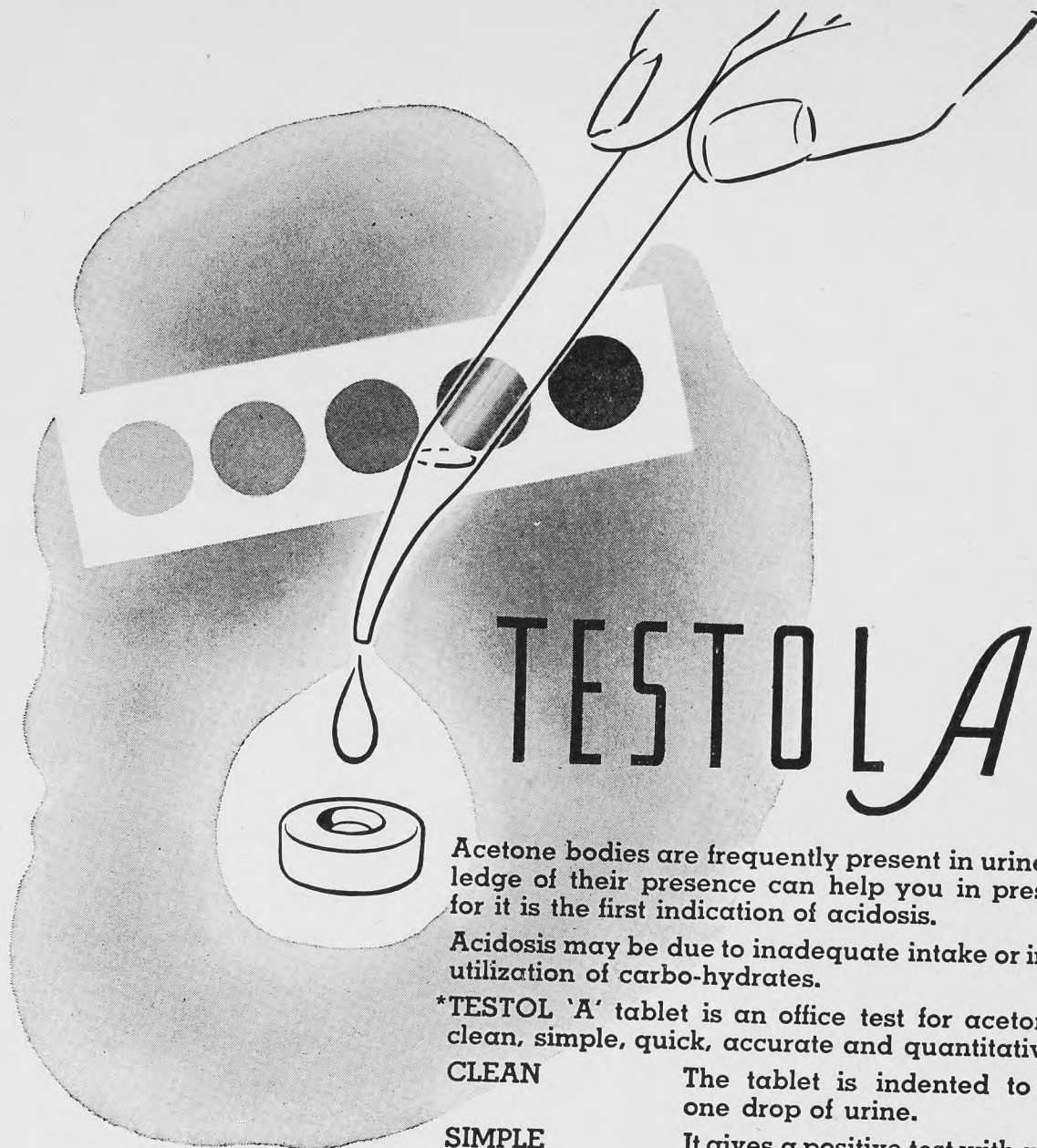
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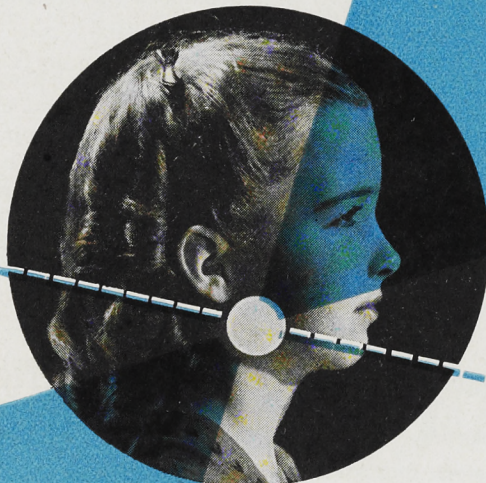


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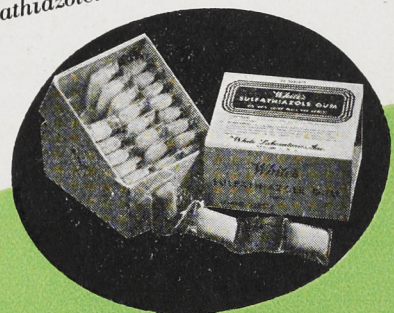
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## Penicillin in Venereal Disease

K. J. Backman, M.D.

Delivered at the Annual Meeting, Manitoba Medical Association, September 25th, 1945

Penicillin is effective in the treatment of Gonorrhoea, Syphilis and Gangrenous Balanitis. It is of little or no value in chancroid and Granuloma inguinale. It is useless in lymphogranuloma inguinale.

### Low Dosage Penicillin Masks Syphilis

Low dosage penicillin therapy masks or delays early syphilitic lesions.

Sulphonamides have no effect whatsoever on syphilis. Sulphonamides cure chancroid and many non-specific lesions. Therefore, sulphonamides, not penicillin, should be employed pending diagnoses, whenever there is a lesion present that could mean syphilis.

Gonorrhoea and Syphilis are frequently acquired at the same time. The masking of Syphilis in penicillin treated cases of gonorrhoea necessitates follow-up, with a serologic blood test for syphilis, in three or four months.

### Cures Gonorrhoea

Penicillin cures gonorrhoea with a rapidity and certainty unapproached by any other form of treatment.

In Gonorrhoea the scheme of penicillin therapy that has proven the most effective and has withstood the test of time, is to administer 20,000 units intramuscularly, at three-hour intervals, until the required total dosage has been given.

In uncomplicated Gonorrhoea, the minimum effective dosage is 100,000 units for males, and 200,000 units for females. A second course is sometimes necessary and occasionally a third. A much more effective dosage is twice the aforementioned.

In gonorrhoeal complications, 400,000 units is the dosage of choice.

If the total treatment period is reduced to 10 hours or less, the failures increase proportionately.

Other schemes that have met with considerable success and are adaptable to office practice are:

(1) A total of 200,000 units injected in 50,000 unit doses, at three-hour intervals. This is the procedure used for ambulatory cases at the provincial clinic.

(2) A total of 200,000 units in two 100,000 unit doses in an eight-hour period. There are more failures if the time interval is reduced to four hours.

(3) One injection only, of 300,000 units penicillin in oil and beeswax. This has recently become available on the market here.

(4) Oral preparations of penicillin given in 50,000 unit doses at three-hour intervals, six times a day for two or three days. However, a better method is to inject 100,000 units of water soluble preparation followed by oral administration for one or two days. This has likewise been placed on the market here recently.

For the present, reliance should be placed only on the water soluble multiple injection method for gonorrhoeal complications.

Variable responses are obtained from penicillin in arthritis. Early cases commonly respond well. In arthritis of long standing results are disappointing. Daily intra-articular injections of 10,000 units in 15 cc. normal saline solution for three days, has sometimes succeeded when other methods have failed.

There are two theories for arthritic failures.

- (1) Avascularity of joint tissues.
- (2) Non-specific arthritis superimposed upon the original gonococcal synovitis.

In gonorrhoeal ophthalmia, parenteral treatment should be supplemented by local instillations. Two to three drops of a dilute solution (500 units to 1,000 units per cc.) are instilled every hour, in grave cases every half hour, until clinical improvement is evident.

Urethral strictures require dilation and should be looked for in obstinate infections.

Although activity of penicillin is not inhibited by moderate amounts of pus and other exudates, large collections require drainage by surgical measures. "Routine Massage" of gonorrhoea infected prostates is unnecessary and may be harmful. This does not rule out prostatic massage after 2 or 3 weeks observation, for the purpose of obtaining prostatic fluid to determine cure.

The criteria of cure varies with different physicians. Dr. Harold Orr of Edmonton followed up 30 women who were institutionalized and had received 200,000 units penicillin. Cultures were done daily for over two weeks. Some did not turn positive until the fifteenth test and one required seventeen sets of cultures. The cure rate obtained on the single course was 60%. Cure rates given by some investigators are as high as 95%.

I suggest that six weekly sets of smears in females and three weekly prostatic smears beginning in the third post-treatment week in males, is a reasonable followup, providing other findings are negative. Cultures are preferred where possible.

Experiments have failed to produce penicillin resistant gonococci, on increasing concentrates of penicillin in culture media. Sulphonamides have, from the beginning, produced sulphonamide resistant gonococci under similar experiments. It is feared that with lapse of time, gonococci in body tissues will adapt themselves to penicillin. So far this has not been evident either in gonorrhoea or syphilis, as relapses have responded as promptly as did the initial attack.

#### **Immediate Effects Favourable in Syphilis**

Dr. John Stokes says "It takes a year to guess, two years to intimate, five years to indicate, a decade or more to know what penicillin does in syphilis."

The immediate effect is superior to any former therapy in terms of:

- (1) disappearance of *Treponema Pallida* from open lesions.
- (2) healing of lesions in early and late syphilis.
- (3) serologic reversal.

#### **In Early Syphilis Apparent Cure Rate Favourable**

In early syphilis the relapse rate is inversely proportional to the total dosage employed.

In early syphilis the time of the blood serologic reversal from positive to negative is in no definite relationship to the total dosage. The reversal in some cases is sudden, as a general rule, however, the graph of its fall resembles the temperature fall by lysis of an acute fever. It may take anywhere from two to twenty weeks. If, in early syphilis, the blood test is strongly positive at the end of three months, the patient should be re-treated.

The abnormal cerebro spinal fluid in early syphilis improves with even greater rapidity than does the positive blood. Excellent response is obtained in early neurosyphilis.

Dr. J. E. Moore states "The intrathecal injection of penicillin in patients with early neurosyphilis is not necessary; although the drug does not penetrate into the cerebro-spinal fluid, it does penetrate the diseased tissues of the nervous system. This is almost certainly true also of late syphilis."

In the prevention of congenital syphilis, penicillin appears to be effective.

Results from the treatment of infantile congenital syphilis have been favorable. The dosage for this purpose has ranged from 10,000 to 30,000 units, per pound body weight, employed in 8 to 12 days. Our experience has been that the higher dosage is advisable.

The present day standard method of treatment in adults is to inject 40,000 units intramuscularly, at three-hour intervals, day and night, for sixty injections, or, a total of 2,400,000 units in 7½ days. The optimum time dose relation is not known. The

intramuscular route has consistently given better results than the intravenous route.

Studies in animal and man suggest that a few injections of mapharsen, administered during a course of penicillin therapy, gives better results than by the use of penicillin alone.

The schedule of treatment now employed in the Army in Canada, is to administer penicillin as previously mentioned, with the addition of mapharsen .06 gms. on alternate days, for four injections, and bismuth salicylate 2 cc. twice, within the 7½ days.

Drs. Lloyd Jones and Gordon Maitland of England report favourable effects from one single large penicillin injection daily. They administer 300,000 units to 500,000 units at a time. The total dosage is 2,400,000 units to 3,000,000 units. Fifty-six patients have been so treated.

The suggested procedure of post-treatment follow-up is a "check-up" including a blood serologic test for syphilis every two months for six months, at which time a spinal fluid test is also done. Then further "check-up" and blood test at three-month intervals for a further eighteen months. Yearly follow-up is advisable for another three years.

Statistics to date suggest that the relapse rate from penicillin in early syphilis may prove to be 20%. This is no worse than formerly obtained from the best known methods. Of course, further reduction is made by re-treatment. Results in sero negative primary syphilis is much better with either penicillin or metal chemotherapy.

With former methods, in early syphilis 71% of relapsers relapsed within the first post-treatment year and 93% of relapsers relapsed before the end of two years. Only two years and three months have elapsed since penicillin was employed for the first time in syphilis.

#### **In Late Syphilis Completeness of Effects Unknown**

In late syphilis the blood serologic reversal from positive to negative is erratic and not notably effective. However, a higher proportion of cases are rendered negative than was formerly possible from metal chemotherapy.

In late syphilis the reversal of abnormal spinal fluids is much more successful. Spinal fluid reversals are common, even after large amounts of standard treatment, over long periods have failed.

In symptomatic late syphilis there is usually some immediate clinical improvement. Whether this is as frequent or as complete as after former methods is not known.

Reports are encouraging in late neurosyphilis. Even paresis has responded favourably. Charcot joint gives no response. There is probably some favourable response at times in primary optic

atrophy, at any rate no bad effects have been observed.

Lightning pains respond at least as well as from other types of treatment, and at times succeed when others fail. Sometimes the response in interstitial keratitis is dramatically favourable, but just as often the response is disappointing.

Four schedules of treatment are now under trial for late neurosyphilis:

(1) Repeated courses of relatively small doses, e.g. 1,000,000 units separated by rest intervals. This is especially for the less serious forms of Neuro-Syphilis.

(2) Single massive dose courses 2,000,000 to 6,000,000 units given in eight to twenty days or more, for paresis, pre paresis and primary optic atrophy.

(3) Malaria plus penicillin simultaneously — a total of 2,000,000 to 4,000,000 units. Penicillin does not influence the course of therapeutic malaria.

(4) Malaria followed by penicillin.

#### Herxheimer Reactions

Penicillin reactions are usually minor. However, a Herxheimer reaction is occasionally severe.

Pain accompanying intense local reaction in chancre and bubo may necessitate administration of analgesics. Fever and chills in early syphilis may be quite alarming, but this is no indication to decrease or discontinue penicillin. The chills occur in three to six hours and last about four hours.

In late syphilis reactions in focal lesions, in vital structures may be grave. Grave reactions may also occur in severe infantile congenital syphilis. Reduction of dosage by one-half, for one or two days is necessary. This should be compensated for by prolonging the course and increasing the total dosage.

#### Summary of Schemes of Penicillin Therapy in Venereal Disease as of September, 1945

Revision may be necessary as experience accumulates.

Injections are intramuscular unless otherwise specified.

**Genital lesion**, pending diagnosis:

Sulphonamides: **NOT** penicillin.

Low dosage penicillin MASKS syphilis.

#### Gonorrhoea

##### In-patient:

20,000 units at 3-hour intervals, day and night.

Minimum effective dosage—cure 70%.

Male, 100,000 units

Female, 200,000 units

"Adequate Dosage"—cure 90%

Male, 200,000 units

Female, 300,000 units to 400,000 units

In complications use "adequate dosage" or more.

##### Ambulatory:

1. 50,000 units at 3-hour intervals—Total 200,000 units.
2. 100,000 units give twice in 8 hours—Total 200,000 units.
3. 100,000 units give twice in 4 hours—Total 200,000.
4. 300,000 units in oil and beeswax—Once only.
5. 50,000 units Oral penicillin at 3-hour intervals, 6 times a day for 2 or 3 days.
6. 100,000 units water sol., one injection, followed by Oral penicillin for 1 or 2 days.

##### Extra:

1. **Resistant Arthritis** — 10,000 units in 15 c.c. normal saline sol., intra-articular, daily for 3 days.
2. **Ophthalmia** — Parenteral plus local instillations, 2 or 3 drops hourly, 500 to 1,000 units per c.c.
3. Wasserman in 3 or 4 months on penicillin treated gonorrhoea patients, to catch MASKED syphilis.

#### Syphilis

##### Early:

1. 40,000 units, at 3-hour intervals, day and night —Total 2,400,000 units (7½ days)
2. Total 2,400,000 units  
Mapharsan, .06 x 4  
Bis. Sal., 2 c.c. x 2  
All within 7½ days.
3. 300,000 units, once daily for 8 days,  
or  
500,000 units once daily for 6 days.  
(Still in experimental stages.)

##### Late Neuro:

1. **Mild cases**—40,000 units every 3 hours, night and day—Total 1,000,000 units.  
Rest interval:  
Repeat course (times according to progress).
2. **Paresis, Preparesis, Primary Optic Atrophy**—40,000 units every 3 hours, night and day  
Total 2,000,000 units to 6,000,000 units.
3. Malaria plus penicillin concurrently — Total 2,000,000 to 4,000,000 units.
4. Malaria followed by penicillin.

##### Infantile Congenital:

1. 20,000 to 30,000 units per pound body weight, in 8 to 12 days.

If further information relative to venereal diseases is desired, communicate with:

Director of Division of Venereal Disease Control,  
Manitoba Department of Health and Public  
Welfare, 320 Sherbrook St., Winnipeg.

## Barbiturate Poisoning

J. C. Hossack, M.D., C.M.

Poisoning by the compounds of barbituric acid is becoming increasingly more frequent. These compounds are used very widely and very freely. No less than 1,620,000,000 grains were manufactured in 1936 and according to McNally (quoted by Lawrence) this astronomical figure was doubled by 1943. That is to say that about five million one-and-a-half grain doses are consumed daily. No wonder that overdosage is not uncommon.

Barbiturate poisoning can occur in a variety of ways. Some people have an **idiosyncrasy** for these drugs and intoxication takes the form of a "hangover" with depression (sometimes excitement), dizziness, unsteadiness, nausea and the appearance of inebriation. There may also be aches and pains in various regions. People who are subject to allergic manifestations are particularly likely to suffer from cutaneous lesions such as swellings of the eyes, lips and face, erythematous rashes and dermatitis. **Chronic poisoning** occurs when long acting barbiturates are given over long periods and in moderate dosage. There is a tendency for physicians to prescribe doses much in excess of those actually needed and to continue them for a longer time than is justified. Patients thus overdosed become "dopey", thought is sluggish, memory is poor, the mind is confused, concentration and decision are difficult. In addition various neurological signs and syndromes appear referring to both cranial and peripheral nerves and to both motor and sensory spheres. Rashes of various sorts are not uncommon, the more usual being morbiliform or scarlatiniform in appearance. Urticarial and bullous eruptions, dermatitis, attended at times with great itching and at times with fever give a confusing picture. Diagnosis of chronic barbiturate poisoning is so bizarre and so multiform in its manifestations that its diagnosis is largely a matter of having the condition in mind.

**Acute poisoning** may be accidental or deliberate. In the former case it is most often the result of what Richards calls "automatism". The first dose (taken at bedtime usually) dulls the senses and so disturbs the memory for recent events that the patient, not realizing what he is doing, continues to take tablet after tablet quite automatically until the supply at hand is exhausted. If the available amount be large death may occur and be wrongfully attributed to suicide. Elderly people, in whom cerebration is already disturbed, are especially prone to automatism and it should be guarded against by placing some one other than the patient in charge of his medicine. Acute accidental poisoning may occur in children whose

curiosity leads them to find and to sample some barbiturate left within their reach.

Deliberate overdosage is common. The desperate and despairing, seeking for a way to loose the silver cord, find in these drugs, so easily obtained, so easily taken, so gentle in action, the most satisfactory means for accomplishing their desire. Of the non-traumatic methods of committing suicide barbiturate poisoning is the most common. The degree of intoxication depends partly upon the drug and largely upon the person who takes it. The toxicity of the different barbiturates varies considerably so that the lethal dose is set at from 15 times to 30 times the therapeutic dose. The amount taken, however, bears no constant relationship to the degree of poisoning. Much more important than the drug or the quantity are the age and condition of the patient. The weak and debilitated, the sufferers from toxemia and sepsis, the individuals with chronic cardiac, pulmonary, renal, or hepatic disease, the anaemic and thyrotoxic—all such persons are easily intoxicated even by small doses. For them moderate dosage may be dangerous to the point of being fatal.

Chief among the **signs of intoxication** is coma. Before this supervenes there is often a stage of confusion, perhaps excitement, ataxia and vomiting, but these evidences of intoxication are rarely seen for they occur at a time when the patient is unattended. There is nothing characteristic about the coma. The patient is quiet, limp, usually pale. The attitude and appearance are those of a patient who is recovering from a barbituric anaesthetic, or rather who is under one. The pupils may be normal in size or dilated or contracted. Contraction is more common in severe cases and in these the light reflex is usually lost. In less severe grades the pupil is larger and the stimulus not seldom produces hippus. This alternate dilatation and contraction of the pupil is regarded as a favourable sign. The corneal reflex is lost. Nystagmus and strabismus are seen in mild degrees of intoxication or when the patient is approaching consciousness.

Breathing varies from quiet shallow respirations through various grades of polypnoea to Cheyne-Stokes rhythm. In severe cases dyspnoea is constant. For this there are several reasons—depression of the respiratory centre, accumulated secretions in the bronchi, atelectasis as a result of these secretions, and bronchopneumonia. Pulmonary complications are serious, pneumonia (veronal pneumonia) always threatens, and usually takes, life; its signs usually appear 48 hours or

so after coma begins. The pulse may be normal in rate or rapid; good in quality or weak. The blood-pressure does not fall until late and the fall is due to anoxia. The abdomen is soft and its reflexes are absent. The bladder, having lost its sensibility, remains unemptied. The legs and arms are limp. All tendon jerks are absent. Babinski's sign is frequently present (as it is in all comatose states) but is of no special significance. The signs of Brudzinski and Kernig are absent. Fever occurs even in the absence of complications and appears usually in 24 to 48 hours. Rarely hemiplegia or facial paralysis may be seen and skin eruptions,—erythematous, urticarial or bullous—are occasionally present.

In the absence of a history of taking a sleep-producing drug—and such a history is usually absent—**diagnosis** must be made by exclusion. It is usually easy to exclude **trauma**. The **alcoholic** is stuporous rather than comatose. Deep, noisy breathing and the smell of acetone upon the breath differentiate **diabetic coma**. **Uremia** is associated with characteristic changes in the eye-grounds and in the blood chemistry, and has, moreover, other positive signs. The meningeal syndrome, which is present in all forms of **meningitis** and also in **subarachnoid haemorrhage**, is never found in barbiturate narcosis. **Cerebral vascular accidents**, angiospasm, haemorrhage, embolism and thrombosis, are not likely to cause confusion. The patient in **post-epileptic coma** will bear upon him the marks of his recent struggle. In **opium or morphine poisoning** the pupils are tiny, the skin pale and drenched in sweat, the pulse and respirations slow and weak. The unconscious stage of **carbon monoxide poisoning** is characterized by the cherry-red color of the skin. Other causes of coma are too rare to be considered unless signs of them are uncovered in examination.

Absence of definite signs of these conditions excludes them but the presence of such signs does not exclude the possibility of superadded barbiturate poisoning. Scarlett and Macnab report the case of a girl who suffered from encephalitis but died from barbiturate intoxication. When the clinical picture is suggestive but definitely atypical it is at least desirable to seek for barbiturate excretion products in the urine and in the spinal fluid lest the fuel of more poison be added to the fire of narcosis.

When one is satisfied that barbiturate poisoning is responsible for the coma treatment should be started at once. The **Principles of Treatment** are these: 1. To prevent further absorption of the drug; 2. To neutralize the absorbed drug; 3. To ensure elimination of the absorbed drug; 4. To protect and strengthen the lungs and heart; 5. To support the patient's strength. Each of these principles will be discussed separately and

then their combination and practical application in treatment will be outlined.

1. **Prevention of further absorption** is accomplished by gavage. Stomach washing is advised even though the drug was taken hours before. Vomiting may not have completely emptied the stomach and persisting pylorospasm may cause its retention for later absorption. The washing should be repeated two or three times with warm water. Under no account should sodium bicarbonate be used because that might mean increasing the solubility of the drug and aggravating the symptoms. Some writers advocate the use of potassium permanganate in a strength of 1 in 2,000 to 1 in 5,000, but this seems to be of value only when Dial is the poison concerned.

2. **Neutralisation of the absorbed drug** is accomplished chiefly by the use of analeptics for there is no direct antidote for the barbiturates. There is some question as to the exact site of barbiturate action. It has been thought that they accumulated in and about the hypothalamic vegetative centres, and some authorities (Keeser and Keeser) have reported special concentration in the thalamus and striatum. Pick and others report a selective depression of mid brain centres. Other workers find that barbiturate concentration is approximately equal in all parts of the brain. There is also a depressant action on the spinal cord. The drugs most antagonistic to the action of the barbiturates are strychnine, ephedrine, coramine, metrazol, and picrotoxin. Each of these has its advocates. **Strychnine**, highly extolled by Marri, has its chief action upon the spinal cord but also has an effect upon the medulla. Under ordinary circumstances the large doses necessary to evoke medullary response limit its use but large doses can be given with comparative safety when the centres are abnormally depressed by drugs. The dosage advised is 2 to 10 milligrams (1/30 to 1/6 grain) every two hours. In extreme cases it may be given intravenously. **Ephedrin**, a powerful sympathomimetic agent, produces many desirable effects. It raises the blood-pressure, stimulates the heart directly, dilates the bronchi, and stimulates the respiratory and the vasomotor centres. Ten to thirty milligrams (1/6 to 1/2 grain) may be given every hour or two. **Benzedrine** is similar in action to ephedrine but its central action is stronger and its peripheral action is weaker. **Coramine** (Nikethamide) is of considerable value. Although not a potent analeptic it has the advantage of being safe. Its action is exerted through the carotid sinus chiefly but it also acts upon the medulla and is credited with a direct action upon the coronary arteries which it dilates. There is a wide margin of safety and large doses should be given. McDaniel and Bell recommend 5 cc. intravenously every 5 to 10

minutes until improvement shows. Others are content to give the same dose intramuscularly at longer intervals. The size of repeated doses and the rate of repetition are governed by the course of the case. **Metrazol** (cardiazol) is a powerful central nervous stimulant which acts primarily on the higher centres but acts also upon the medulla, where it is particularly effective on the respiratory centre although it stimulates the vasomotor centre also. Its action in barbiturate poisoning is to off-set the depression of the medullary centres. To this end Kutschera-Aichberger gives doses of 5 to 10 cc. intravenously every hour till the patient is awake. He points out that, in the presence of barbiturate poisoning, this dose is well within the limits of safety. **Picrotoxin** is the newest analeptic used in this type of coma. It is a strong stimulator of the cortex and an even more powerful stimulator of the midbrain and medulla. In addition to these actions it also stimulates respiration indirectly by decreasing the narcosis. The fact that it is probably the strongest of all the analeptics has made it a very popular one for use in barbiturate narcosis. Indeed that is its sole therapeutic property and indication. It is given intravenously in a concentration of 1 in 1,000, and at the rate of 1 cc. per minute until there is return of the corneal reflex or until there is facial twitching. When this stage has been reached the size of the dose is lessened and the interval between doses is increased. Gardner recommends a dose of 3.0 mg. or 1 cc. of a 0.3% solution intravenously every 20 minutes until twitching occurs. Anderson gives 3.0 mg. every minute until the patient responds. Thereafter the same amount is repeated hourly or every two hours. Dorsey employs an intravenous drip apparatus into the tubing of which he injects the picrotoxin solution in dosage sufficient to rouse the patient and keep him roused. His initial dose is 1 cc. per minute. Picrotoxin has only a narrow margin of safety. Overdosage causes convulsions and some authors advise that a solution of a quick acting barbiturate be kept ready for use in the event of treatment being too effective. Convulsions should be avoided because after them depression is deeper. In barbiturate narcosis there is a greatly increased tolerance to picrotoxin and 50 to 150 milligrams are not unusual total doses. In fact in one reported case the total dose was 671 mgm. Moeschlin and Schoelly regard picrotoxin administration as dangerous when the corneal reflexes are obtainable.

3. **Elimination of the absorbed drug** is important. It is accomplished through the **bowel** by leaving a solution of magnesium sulphate or sodium phosphate in the stomach after gavage. The bowel should be cleansed by enema. The **bladder** should be emptied by catheter every six

hours. This will prevent any reabsorption that might occur if the drug is excreted in any quantity. Barbiturates find their way into the **spinal fluid** and consequently the canal should be drained freely every 12 hours. Intravenous infusions have been advised as a means of increasing body fluids and encouraging excretion. Where the condition of the heart is satisfactory these are probably safe enough but an adequate amount of fluid can as easily and much more safely be supplied through a nasal tube, a Murphy Drip, or by injection under the fascia lata.

4. **Protection of the lungs and heart** is a matter of prime importance. Death, when it occurs, is most often due to pneumonia—"veronal pneumonia" it is called because of its association with the oldest member of this group of drugs. There is danger of aspiration during vomiting or stomach washing and every effort must be made to prevent such aspiration. Signs of bronchopneumonia may appear early but usually lung changes are not noticed before the second or third day. Hypostatic congestion also may supervene but can be delayed or prevented by frequent change of position. It is important to keep the air-way clear by repeated aspiration of the secretions which accumulate in the mouth and throat. In that way the lung is less likely to become the seat of trouble. Pneumonia is a very dangerous complication. Anderson has in three cases combatted it successfully with sulphapyridine but as pointed out by Adriani, the sulpha drugs potentiate the barbiturates and for that reason must be used with caution. When respiration is very shallow artificial respiration may be needed and for this purpose a respirator is useful. Oxygen also is then indicated but in its use it is important to remember that "The respiratory depression in barbiturate narcosis is so refractory to the normal stimulus, carbon dioxide, that doubt has arisen whether it plays a major role in the regulation of respiration. Its antidotal effect is minimal. Oxygen exchange and cellular metabolism are at a low ebb. Breathing continues mainly under the influence of this anoxia. The administration of oxygen, by removing this stimulus, may induce fatal apnoea." (McDaniel and Bell.) Oxygen when given should be in combination with carbon dioxide. In addition to these direct methods of guarding against lung complications the drugs previously mentioned have a stimulating effect upon respiration. The heart by itself does not seem to be particularly vulnerable but vasomotor collapse does occur. Ephedrine and coramine are of particular value both in prevention and treatment.

5. **The maintenance of the patient's strength** is necessary for the comatose period may extend over three or four days. Nasal feedings should

be given every 6 hours and the "meals" ought to consist of coffee, glucose solution, egg-nogg, and similar nourishing liquids. Between "meals" much water should be given in order to dilute the retained drug, hasten its elimination, supply the tissues with needed fluid and restore the fluids lost by elimination.

Having now discussed the principles and rationale of treatment we can proceed to their application in a case of poisoning. First there are **rules applicable to all cases**. The patient is kept in bed with his head low and turned to the side. The stomach is washed out with warm water care being taken to prevent the entry of fluid into the air passages. An ounce or two of magnesium sulphate or of sodium phosphate is left in the stomach. The nasal tube is left in place for subsequent feeding. The air-way is kept clear by aspiration if necessary. The colon is also washed out and, if desired, fluid can be left in the bowel or a Murphy Drip can be set up. The bladder is emptied and spinal puncture done. Then the patient is warmly wrapped in blankets. These orders are applicable to all cases. Subsequent treatment depends upon the degree of coma but chiefly upon the age and general condition of the patient.

**The elderly victim of automatism** will not likely have ingested a very large dose and the exact dose can often be determined. The danger lies less in the drug than in the constitution of the patient. For such cases the gentle analeptic coramine is the preparation of choice. It may be less potent but it is certainly more safe than the other remedies of that class. Depending upon the degree of coma an initial dose of 3 to 5 cc. may be given intravenously. Unless the condition is very grave subsequent doses of the same size can be given intramuscularly. Ephedrine is indicated if the blood-pressure is low. Oxygen mixed with carbon dioxide will improve the respiratory state. Feedings of coffee, glucose solution and the like are given every 6 hours with plain water between times. Intravenous injections are best avoided in the aged. The *viae naturales* are better because that is what they are. The elderly patient who is chronically ill and in poor physical condition is in a serious state but the use of strong measures is more likely to hasten than to avert death. Automatism in the young is not unknown and in them treatment should be more energetic.

**The patient who is young and vigorous** and who has taken a very large dose with suicide in mind can stand and requires more heroic treatment. Picrotoxin is probably the drug of choice and, as the heart is not likely to be impaired, it can be given by the method suggested by Dorsey, that is by injection into the tube of an intravenous drip. One cc. of a solution of 1:1,000 in strength

is injected every minute until the corneal reflex returns. Thereafter the dose is reduced so that about 3.0 mgm are given in an hour or in two hours, the patient meanwhile gradually recovering first his reflexes and then his consciousness. It is necessary to keep up the administration because secondary lapses into unconsciousness are not infrequent. An idea of the amount required has already been given—ordinarily from 50 to 150 mgm and on one occasion at least, over 600 mgm. Should the picrotoxin cause convulsions these can be controlled by avertin or indeed any barbiturate.

Metrazol can be given intravenously in 5 to 10 cc. doses. Here also there may be relapse if treatment is interrupted for too long a period. Ephedrine is most valuable when the blood-pressure is low and may be used to prevent the fall. Coramine, despite its lower potency is often quite satisfactory. It cannot be counted on to end the coma quickly. The advocates of picrotoxin and metrazol push these drugs so as to re-establish consciousness in a matter of hours if possible. Coramine will not produce (unless in heroic doses) so speedy an effect but the secondary lapses are not so likely to occur because there is not the same need to guard against harmful reactions. The best plan is to use picrotoxin or metrazol to "break the spell" and to follow up with the safer remedy. This is the method advised by Lovibond and Steel. In this way there is not likely to be a return of the coma and the coma itself may end more quickly. When coramine is used ephedrine also should be given. It is particularly valuable in peripheral vascular collapse, a condition which makes its appearance when the coma has lasted over 24 hours. It is useful, also, in respiratory failure for which artificial respiration is indicated and oxygen with carbon dioxide is given.

In addition to the special therapy suggested above it is necessary to repeat the spinal drainage, catheterise the bladder and supply fluids and nourishment through the nasal tube. These are the methods to be followed in the two principal types of poisoning. The exact procedure to be followed in any individual case depends upon the condition of each individual patient. The recovery of consciousness is not the end of the matter for pulmonary complications may not appear until then. The patient remains a patient until it is apparent that he is well.

The outline given above may be regarded as the generally accepted procedure in cases of barbiturate poisoning. Patients, can, however, recover from severe poisoning without being submitted to drastic measures as the accompanying cases will show. To be sure we were dealing with young and otherwise healthy people, which serves

to emphasize the importance of the general condition in prognosis as well as treatment.

Case I. A girl of 2½ was noticed by her mother to behave strangely. She seemed to be dizzy and staggered around as if she were drunk. This kept up and increased for about an hour until the child went to bed and to sleep. The mother being unable to rouse her child, became alarmed and took the youngster to Dr. Fishman who took her to hospital. Dr. Fishman suspected barbiturate poisoning because, shortly before, he had prescribed phenobarbital for the mother. Subsequent search revealed only the empty box and the inference was that the child had taken at least 12 grains, an amount equal to 60 grains in an adult. When seen in hospital she was somewhat pale and deeply comatose. The pupils were somewhat small. The light reflex could be seen as a very slight movement through a plus lens in the ophthalmoscope. The fundi were normal. The corneal reflex was abolished. Strong pressure over the supra-orbital notch evoked the slightest possible response. There was no smell upon the breath. Respirations were a little slow and shallow. The pulse was 90. The blood-pressure (systolic) was 60. The abdomen was soft and its reflexes were absent. The arms and legs were completely limp. All tendon jerks were absent. Babinski's, Brudzinski's and Kernig's signs were absent. Both sides of the body were the same. The urine was negative. All the common causes of coma could be excluded. It therefore seemed certain that Dr. Fishman's diagnosis of barbiturate narcosis was correct, although we did not at the time have the evidence of the empty box.

There was no question about the general measures to be ordered i.e. gavage, removal of secretions, enema, fluids and feeding by nasal tube and so on. There was a question, however, as to the analeptic of choice in such a case. Strychnine, metrazol and picrotoxin all seemed to be too dangerous for use in such a small patient even though the intoxication was deep. We determined, therefore, to rely on coramine chiefly and to use ephedrine if the condition did not improve. The stomach was washed out, the spinal canal was drained (the fluid was under a slightly increased pressure but was normal) and the head kept low. Then coramine was given through the nasal tube for slow action, and hypodermically. The first dose was 1 cc. which, at the child's age was equivalent to 7 cc. in an adult. The drug was repeated hypodermically at lengthening intervals and in doses of 0.5 cc. By the next day response to painful stimuli was more pronounced. The treatment was kept up while reflex response improved until by the morning of the third day she was awake and active. The temperature rose on the second day to 100 with no signs of complication in the lungs or elsewhere. Throughout the

illness water, milk and egg-nogg were given freely.

Case 2. A man of 22 deliberately swallowed 13 ½ grain tablets of Soneryl at 1 a.m. He was brought to hospital by the police at 5 p.m. deeply comatose. The physical findings were of intoxication. Routine treatment was instituted and in addition he was given 100 cc. of 25% glucose in saline intravenously. Coramine was given subcutaneously in 1 cc. doses at intervals of about two hours. The blood-pressure did not fall below 100 systolic and his pulse was of good quality and about 90 in rate. He walked out of hospital on the third day.

Case 3. A woman of 21 attempted to commit suicide by taking 60 one-grain tablets of phenobarbital. She was discovered in coma five hours later and taken to hospital. She had all the findings of a person in profound barbitural narcosis. Even strong stimulation caused no response. Gavage, enema, spinal drainage were all done and the latter repeated on three occasions at 12-hour intervals. The systolic blood-pressure was 80 and the pulse was weak and rapid. She was given coramine 5 cc. intravenously and then 5 cc. intramuscularly, first hourly and later at intervals of two, three and four hours; later doses being reduced to 3 and then to 2 cc. Ephedrine was also given every four hours in ½ grain and then ¼ grain doses. She gradually emerged from her coma in the space of four days, and, as she was approaching full consciousness she told (in answer to questioning) the circumstances under which she took the drug. She was watched for a few days after she became conscious but no complications appeared and she was discharged walking and well.

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## Hypothyroidism

H. D. Kitchen, M.D.

The clinical syndrome of the condition caused by a lack of thyroid function has been recognized since Orde in 1878 and Gull about the same time described a cretinoid state occurring in adult women. Textbooks contain classic descriptions of this condition termed myxedema and describe an individual exhibiting a profound metabolic disturbance, which is manifest in a marked sluggishness of the mental and physical processes so that thinking becomes a bore and physical exertion too much of an effort. Trophic changes are evident in the dry, wrinkled and scaly skin, the puffiness of the face, the scanty brittle hair and the coarse nails. The pulse rate is slow and the blood pressure below normal; obesity is usually marked; there is often a malar flush and finally the basal metabolic rate is usually minus 30 or lower. In addition, the symptoms are said to be aggravated by cold weather. In the case of women amenorrhea is frequent and sterility common.

Perhaps because of this detailed description there was for many years a failure to recognize the fact that many patients presented symptoms due to varying degrees of hypothyroidism ranging from a very mild deficiency to an almost total lack of secretion, which alone would produce the classical picture outlined above.

One encounters comparatively few patients with definite myxedema. On the other hand, there are many people, particularly in this part of the world, who do have varying degrees of hypothyroidism. The recognition of these and the appropriate treatment is extremely important because, although they may lead useful lives, their efficiency is greatly impaired. The symptoms of hypothyroidism will vary tremendously, dependent, to a great extent, on the severity of the deficiency.

**Tiredness** or undue fatigability is usually the outstanding complaint. This symptom, of course, may be merely a result of the stress of modern living or may be caused by Anemia, Tuberculosis, Diabetes or other debilitating conditions. The latter must be ruled out in the course of examination.

**Intolerance to cold** manifests itself especially in a liking for excessive warmth indoors, multiple bed covers, and so on. This may not be complained of, but judicious, although not leading questions, may elicit this information.

**Dry hair and skin** or brittle nails may have been observed by the individual, but these may not be striking enough to have attracted attention.

Finally, none of the foregoing may be among the patient's complaints and he may have anemia, flatulent dyspepsia, or joint pains. Women may have menstrual disturbances with frequency and amount of blood loss usually decreased but occasionally increased.

Physical examination may reveal nothing abnormal although perhaps the hair and skin may appear to be a little more dry than usual.

The basal metabolic rate, if available, may give readings as low as minus 20 or minus 25. However, the reading may be normal. This procedure is condemned by some as an office practice, but, if care is taken to adequately rest the patient before the test is made, it is of definite clinical value. A second test should always be made if basal conditions have not been secured.

Finally, if a patient is too easily tired and becomes exhausted by midday, and especially if there is intolerance to cold, the judicious use of thyroid extract is well justified even if the basal metabolic rate is normal or cannot be obtained.

**Treatment with thyroid preparations**—Some years ago treatment was initiated by thyroxin given intravenously. It was found that each milligram of this substance would raise the basal metabolic rate 2.5 points. It was also noted that the effect was not immediate but reached its maximum in about ten days and then as gradually tapered off. However, this method was costly and time consuming and, since it was learned that thyroid preparation given orally will accomplish the same result, although more slowly, the intravenous method has been largely discontinued. At present, therefore, most substitution therapy is carried out by the oral administration of thyroid preparations.

No definite rule regarding dosage can be given but a few suggestions may be made.

(1) Remember that the dried or desiccated thyroid is five times as potent as the whole gland preparation.

(2) Be sure and use a product made by a reliable drug firm.

(3) Keep in mind that the action of thyroid is cumulative. Therefore, start with a relatively small dose— $\frac{1}{2}$  grain twice daily and do not increase the dose for 2 or 3 weeks. At that time, if progress is not satisfactory, the amount may be increased. Some people with extreme degrees of hypothyroidism will feel best on  $\frac{1}{2}$  grain of desiccated thyroid daily while others will require 2 grains. The correct dosage, and it may take several months of carefully supervised treat-

ment to arrive at it, is the amount of thyroid required to attain maximum well being for the individual. The level of the basal metabolic rate is of secondary importance but usually when the patient feels best it will be found to be around minus 5.

If, in the course of treatment tachycardia, nervousness, headache, or insomnia develop it is probable that too much medication is being given. No harm has been done, however, and if the thyroid is discontinued for two weeks these symptoms will disappear.

While the correct thyroid dosage is being ascertained, it is necessary to see the patient at frequent intervals, as often as once every week or ten days. Frequent basal metabolic tests are not necessary.

A rapid shift of the basal metabolic rate upwards is often accompanied by headache and an exacerbation of aches and pains all over the body, so that the individual feels worse after treatment

has started. These symptoms will gradually right themselves but it is well to warn the patient that he may feel out of sorts at first. The slower the metabolism is raised the less reaction there will be.

Special caution must be observed in the patient who has hypertension and probably some sclerosis of the arteries. In such there is a very real danger of precipitating attacks of Angina Pectoris. Hence the initial doses of thyroid must be smaller than usual and probably continued at a lower level.

The enteric coated thyroid preparations are a little easier to take but are no more effective. Recently there has been a tendency to combine small amounts of thiamine with the thyroid but the advantage of this has perhaps not been satisfactorily proved.

Lastly—a word of caution: Never give thyroid preparations to reduce weight, unless definite clinical evidence of hypothyroidism exists.

### Doctors Returned to Civilian Practice from Armed Services

The following doctors have been discharged from the services and are now back in practice. Their office addresses and telephone numbers are given so that you may easily inform their old patients where they may be found:

Name	Address	Telephone No.
Anderson, Dr. Julius,	185 Maryland St., Winnipeg	404 065
Bell, Dr. P. G.,	Deer Lodge Hospital, Winnipeg	62 821
Bleeks, Dr. Cherry K.,	105 Medical Arts Bldg., Wpg.	93 273
Carleton, Dr. M.,	603 Boyd Bldg., Winnipeg	94 763
Clark, Dr. C. W.,	216 Medical Arts Bldg., Winnipeg	94 354
Cooper, Dr. Ross H.,	212 Medical Arts Bldg., Winnipeg	93 103
Cram, Dr. J. B.,	409 Power Bldg., Winnipeg	95 165
Croll, Dr. L. D.,	661 Broadway, Winnipeg	72 138
Davidson, Dr. A. M.,	6 Medical Arts Bldg., Winnipeg	95 683
Easton, Dr. S.,	216-7 Curry Bldg., Winnipeg	26 477
Elvin, Dr. Norman L.,	314 Medical Arts Bldg., Wpg.	95 317
Fahrni, Dr. Gordon S.,	105 Medical Arts Bldg., Wpg.	93 273
Hamilton, Dr. Glen F.,	408 Medical Arts Bldg., Wpg.	93 846
Henneberg, Dr. C. C.,	302 Medical Arts Bldg., Wpg.	92 710
Hitesman, Dr. R. J.,	512 Medical Arts Bldg., Wpg.	94 808
Jauvoish, Dr. S.,	206 Boyd Bldg., Winnipeg	93 240
Kobrinsky, Dr. Sydney,	505 Boyd Bldg., Winnipeg	93 912
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Stephenson, Dr. Earl,	409 Power Bldg., Winnipeg	95 165
Walton, Dr. C. H. A.,	Winnipeg Clinic, Winnipeg	97 284
Whelpley, Dr. E. H.,	586 Ingersoll St., Winnipeg	39 061
Brownlee, Dr. T. I.		Russell, Man.
Davidson, Dr. D. A.		Cartwright, Man.
Jacobs, Dr. A. L.		The Pas, Man.

Integrity without knowledge is weak and useless . . . Knowledge without integrity is dangerous and dreadful.—Samuel Johnson.

Angelaus killed Acestorides by operating on him saying, "If he had lived, the poor fellow would have been lame."—Calliacter.

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## Something Old

### Meditations of Sir Thomas Browne

I was never yet once, and commend their resolutions who never marry twice; not that I disallow of second marriage; as neither, in all cases, of Polygamy, which, considering some times, and the unequal number of both sexes, may be also necessary. The whole World was made for man, but the twelfth part of man for woman: Man is the whole World, and the breath of God; Woman the Rib and crooked piece of man. I would be content that we might procreate like trees, without conjunction, or that there were any way to perpetuate the World without this trivial and vulgar way of union; it is the foolishhest act a wise man commits in all his life; nor is there any thing that will more deject his cool'd imagination, when he shall consider what an odd and unworthy piece of folly he hath committed. I speak not in prejudice, nor am averse from that sweet Sex, but naturally amorous of all that is beautiful. ● ● ● ●

I feel not in me those sordid and unchristian desires of my profession; I do not secretly implore and wish for Plagues, rejoyce at Famines, revolve Ephemerides and Almanacks in expectation of malignant Aspects, fatal Conjunctions, and Eclipses. I rejoyce not at unwholesome Springs, or unseasonable Winters: my Prayer goes with the Husbandman's; I desire everything in its proper season, that neither men nor the times be put out of temper. Let me be sick myself; if sometimes the malady of my patient be not a disease unto me. I desire rather to cure his infirmities than my own necessities. Where I do him no good, methinks it is scarce honest gain; though I confess 'tis but the worthy salary of our well intended endeavours. I am not only ashamed, but heartily sorry, that, besides death, there are diseases incurable: yet not for my own sake, or that they be beyond my Art, but for the general cause and sake of humanity, whose common cause I apprehend as mine own. ● ● ● ●

I make not therefore my head a grave, but a treasure, of knowledge; I intend to no Monopoly, but a community, in learning; I study not for my own sake only, but for theirs that study not for themselves. I envy no man that knows more than myself, but pity them that know less. I instruct no man as an exercise of my knowledge, or with an intent rather to nourish and keep it alive in mine own head than beget and propagate it in his: and in the midst of all my endeavours there is but one thought that dejects me, that my acquired parts must perish with myself, nor can I be Legacied among my honoured Friends.—"Sir Thos. Browne, Religio Medici."

## Something New

**Acute infectious lymphocytosis** is a newly recognized contagious disease. The symptoms are, at most, exceedingly mild. They include fever, vomiting, headache and pain in the abdomen but may be so slight as to escape notice. The notable finding is lymphocytosis. The white cell count may be as high as 120,000 with from 62% to 97% lymphocytes. The cells are normal morphologically. The condition appears to be confined to children. In the children's ward of a tuberculosis sanitarium Finucane, Philips and Dale recognized 21 cases. The illness was asymptomatic and lasted about five weeks. Smith of Cornell believes that the cause is a virus.

◆  
In the differential diagnosis of enlarged lymphatic glands **infectious mononucleosis** should be considered. It is characterised by: sore throat, irregular fever and enlargement of glands, spleen and liver. There is lymphocytosis and a considerable increase in the monocytes. A characteristic reaction—the Paul-Bunnell reaction—is present in about 70% of the cases. This reaction is the agglutination of sheep erythrocytes in a titre of 1:128. A positive Wasserman reaction occurs in about 40% but is transient. The disease chiefly affects males but occurs at any age. The Glandular form is seen usually in children. Synonyms are glandular fever and Pfeiffer's Disease. Constitutional symptoms are slight. Glandular enlargements in the neck are the principal findings. The Anginose type appears as a rare complication of the glandular form. A membrane, indistinguishable from that of diphtheria, is seen on the throat. The cervical glands are large and painful. Fever is high. The Febrile variety occurs chiefly in adults. Onset is sudden with headache and chills. In four or five days a maculo-papular eruption appears with recrudescence of fever. There are also sweating and epistaxis. The glands become enlarged about three weeks after the illness begins. Temperature may reach 104. The blood shows monocytes forming up to 70% of white counts as high as 30,000.

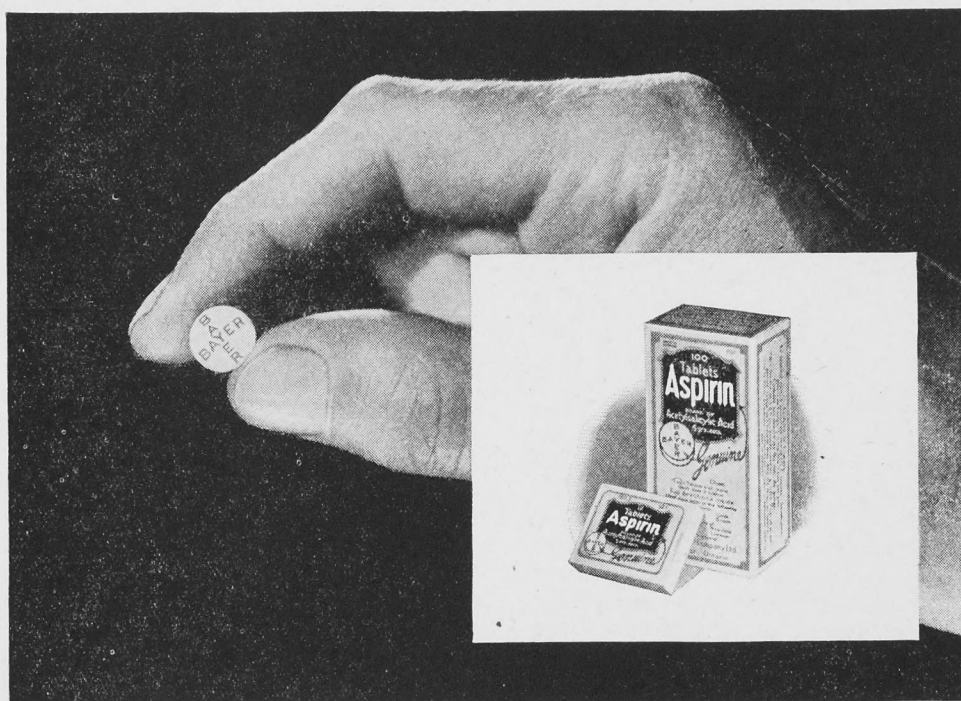
◆  
The pain in **herpes zoster** may be very troublesome. It may appear as much as two weeks before the eruption. Cannon of New York advises X-ray in doses of 200 r (unfiltered) over the affected areas. The dose is repeated in ten to fourteen days. Sometimes a third dose is necessary. He says that ultra-violet light in erythema doses once in 5 to 7 days is also helpful. Other remedies advised are pituitrin (half-strength) 1 cc. every 3 to 5 days; 15 grains of sodium iodide intravenously at the same intervals; aspirin, 10 grains every 4 hours.

Best known and generally considered to be one of the safest, probably the safest, of all analgesic drugs is Aspirin.

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Aspirin, used where properly indicated, can be administered over long periods of time without a decrease in therapeutic effect.

## ASPIRIN





## Winnipeg Medical Society—Notice Board

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C. K. Bleeks, *Treasurer*

R. A. MacPherson, *Secretary*

### The Thirty-third Session

For the first time in eight years our sessions open with the world at peace. In 1938 trenches were being dug in Hyde Park and not even the triumphant flourishing of the Munich Pact by Mr. Chamberlain eased the oppressive feeling that War was being born. And born it was before we met again to open our meetings the next year. Since then there have been dark days and proud days and grim, soul-eating days until the dawn came and the shadows fled away. "Now are our brows bound with victorious wreaths; Our bruised arms hung up for monuments; Our stern alarums, changed to merry meetings." During these past years our numbers have been thinned by the absence of colleagues by the score whose consciences made the rigors of war more comfortable than the safety of home.

For a while it will seem strange to have them among us again. Gordon Fahrni and his decorated son; Roy Richardson, who, as an Officer of the Order of the British Empire, has right of precedence over Gentlemen of the Privy Chamber, the Eldest sons of younger sons of Peers, etc.; Eddie Corrigan, who as a Companion of the Distinguished Service Order, is still farther removed from the Gentlemen of the Privy Chamber, Eldest sons of younger sons, etc.; Vincent McKenty, M.C.; Cherry Bleeks; "Chuck" Walton; and others who have borne the burden and heat of the day. There is one, however, for whom a very special welcome is waiting and that is John Crawford. His name, I imagine, has been in our minds every day since that black Christmas when Hong Kong passed into the hands of the enemy. It will indeed seem like old times when we again see John Crawford and George Shapiro (the long and the short of pediatrics!) discussing the mysteries of an ailing child.

All of these will be back with us again to attend the meetings, to listen and — let us hope — to talk. They can, if they will, tell us much about the grim and the gay in war. What tricks, for example, was our friend Colonel Corrigan up to? I recall that when he commenced his internship he sought out a sympathetic and trustful Sister whom he took into his confidence. He was, he told the Sister, subject to fits. He was ashamed of his affliction and begged her to keep his secret. For these loathsome fits there was but one remedy which was, to him equally loathsome, namely, brandy. Would she, if she found him writhing in agony, pour some brandy down his reluctant throat? Poor Dr. Corrigan! of course she would!

So it came to pass one quiet evening when the corridors were empty and the Sister was on duty that Dr. Corrigan fell into a violent convulsion. Muttering a pious "Mon Dieu," Sister ran for the bottle of brandy and poured one drachm, two drachms, several drachms, past the clenched teeth and into the almost resisting mouth. Well, it was a good trick even if it did work only once.

The present session ought to be a good one. With Youth (in the person of E. S. James, Chairman of the Programme Committee) at the prow, and Beauty (in the person of good-looking Alec. Goodwin, our President), at the helm, we are all set for a pleasant and profitable cruise during the coming winter.



### Sir Thomas Browne

The first regular meeting of the society falls this year on October 19th and so, by chance, on the birthday (in 1605) and the deathday (in 1682) of Sir Thomas Browne. This is convenient for it gives something fitting wherewith to begin the present series of "Notice Boards".

The work which keeps fresh Browne's memory is the "Religio Medici" which has been to many generations of "gentle and meditative" readers a choice classic. Browne was a great favourite of Sir William Osler and the "Religio" was one of his ten "Bedside Books". Later Osler was fated to do a thing most gratifying to the spirit of the old philosopher-physician but of that more anon.

Browne was educated at Winchester and Oxford after which he went abroad to study at Montpellier in France and at Padua in Italy. On his way home he stopped in Leyden and took a degree there. His father had left him a large estate out of a great part of which, says Dr. Samuel Johnson, "he was defrauded by one of his guardians, according to the common fate of orphans." Most of his remaining patrimony he had spent on study and travel so that he was better furnished with knowledge than with money when he embarked on practice near the town of Halifax in 1635. He was young, cultured, lonely. He was given little to do and his whole environment was depressing. His solitary life bred melancholy thoughts and these found expression in the "Religio" and in their expression he found relief. Given little opportunity to mend the body he thought more seriously about the care of the soul. "I cannot go to cure the body of my patient but I forget my profession and call unto God for his soul,"

and he likens the world to "not an inn but an hospital; a place not to live but to die in." This placing of spiritual needs above physical requirements was not likely to make him a cheerful attendant upon the sick and probably those who were his actual or potential patients heaved a sigh of relief when he abandoned his practice.

He moved to Norwich, then the third city in the kingdom, and soon found a footing among the noble and the wealthy. His practice flourished and he himself became well to do. His gloom thereupon was dissipated and in none of his later works do we find the same sadness or the personal application which fills the *Religio*. In his Halifax days he was at least a little misogynous (read the extract given on page under the heading "Something Old"). He had written that woman was but a "crooked piece of man". Fortunately he had also written that he was "not averse to that sweet sex". Anyway he must have been able to give a satisfactory explanation of his position to Mistress Dorothy Mileham for she married him and bore him ten children. He was married in 1641 on the eve of the Civil War. Browne was sympathetic to the Royalists but East Anglia was in favour of the Parliament although determined, if it were possible, to keep the war beyond its borders. During the years of strife he kept busy with his practice and had the sense to keep out of politics. After the Restoration he was knighted by Charles II.

In 1646 he published his second book entitled "Pseudodoxia Epidemica, or inquiries into very many received tenets and commonly presumed truths, which examined, prove but vulgar and common errors." Some of the odd notions included in this curious book are, that the forbidden-fruit was an apple; that storks will live only in republics and free states; that "the flesh of peacocks cor-

rupteth not"; that elephants have no joints; that men weigh heavier dead than alive, and before meat than after; that a pot full of ashes will contain as much water as it would without them, and so on. His knowledge of "vulgar and common errors" did not, however, prevent him from holding as true what we know to be false. One such error was his belief in witches. "Natural diseases" he writes "are heightened to a great excess by the subtlety of the Devil co-operating with witches, at whose instance he doth those villainies." As a result of this opinion two women, accused of throwing a child into fits, were burned at the stake.

"Who knows the fate of his bones or how often he is to be buried?" asks Browne in *Hydriotaphia*. He was buried in the chancel of St. Peter Mancroft but in 1840 a workman while repairing the building accidentally opened the coffin and deliberately took the skull. Later it was placed in the Norwich Infirmary Museum. Written upon a card beneath it were these words from "Hydriotaphia": "To be knaved out of our graves, to have our skulls made drinking-bowls, and our bones turned into pipes to delight and sport our enemies, are tragical abominations escaped in burning burials." It is hard to believe that for seventy-eight years that mute appeal from beyond the grave touched no one's heart, or, if it did, remained unanswered but it was not until 1922 that Sir William Osler, taking pity on his old friend, supplied a fitting casket to enclose the skull and then saw its re-burial with every mark of reverence. Perhaps Osler had that quotation in mind when he gave instructions for his own "burning burial". Only so could he certainly escape the "tragical abomination" of having his own skull "knaved" out of its grave.

J.C.H.

### Golf Tournament Results

The Annual Golf Tournament for the Manitoba Medical Association Cup was played over the Southwood Country Club course on September 27th, under conditions that were more favorable to curling. The official temperature was fifty. A chilly Nor'Wester was blowing and many of the boys swore that it was as frigid as forty. Could it be that Dr. Coad, our master of master starters, handed the thermometer a ten handicap?

Dr. C. M. Clare, carding the lowest net score (90-18-72) was the winner of the Manitoba Medical Association Cup and holder of the trophy for the year.

	Gross	Handicap	Net
Clare, C. M. ....	90	18	72
Warner, N. ....	88	15	73
Richardson, R. W. ....	81	7	74
Johnson, E. ....	95	20	75
Stewart, C. B. ....	100	22	78
Dobbs, E. H. ....	102	24	78
Kitchen, H. D. ....	105	26	79
Fryer, I. O. ....	97	16	81
Bachynski, V. F. ....	105	24	81
Fraser, D. J. ....	97	14	83
Allison, F. G. ....	108	25	83



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*Stable*

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Riboflavin (vitamin B <sub>2</sub> , as soluble salt of riboflavin sodium—sodium tetraborate)	5 mg.
Pyridoxine hydrochloride (vitamin B <sub>6</sub> )	5 mg.
Calcium pantothenate	5 mg.
Niacinamide (nicotinic acid amide)	50 mg.

*effective*

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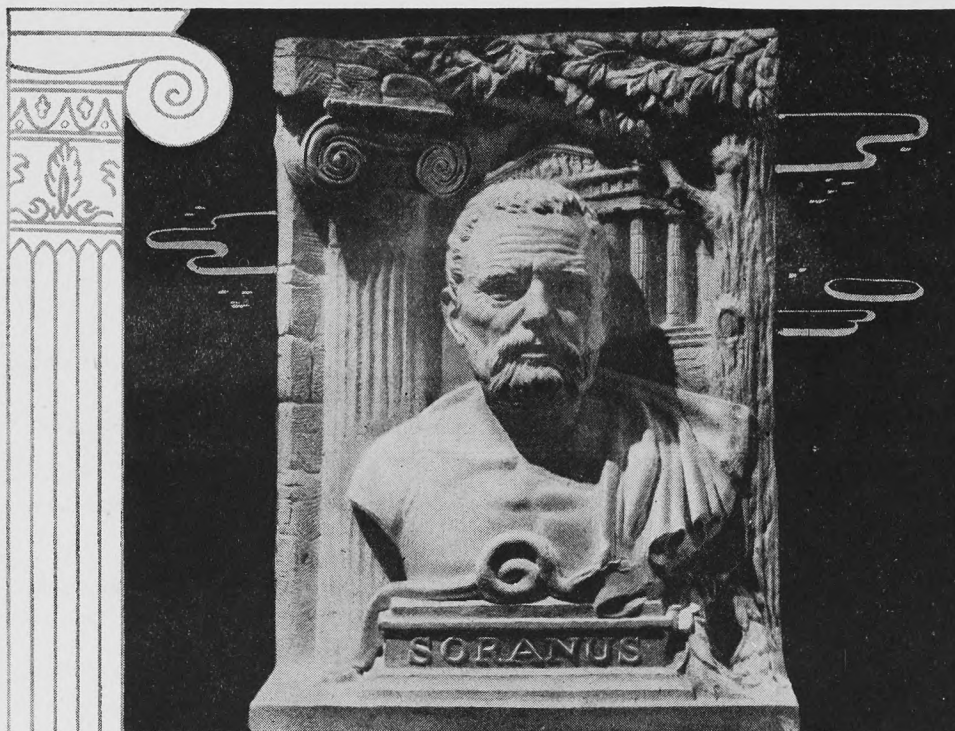
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## Editorial

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J. C. Hossack, M.D., C.M. (Man.), Editor  
R. B. Mitchell, B.A., M.D., C.M. (Man.), F.R.C.P. (C), Associate Editor

---

### The C. P. & S.

The conclusion of the recent successful convention raises the question—would it not be possible to devote one session of the Provincial meeting to the affairs of the College of Physicians and Surgeons? It is an organization with which we are almost completely out of touch. Periodically we elect to its Council representatives who assume their duties without instruction, perform them without direction or criticism and relinquish them without giving any account of their stewardship to those whom they represent. Among the democratic institutions of Western Civilisation our College must stand unique. It is not that the affairs of the College are unimportant or that the members are uninterested. It is rather that over the years Council and members have come to mutually ignore each other. Would it not be more satisfactory to, and much better for, both Council and members if there were between them closer and more frequent contact? With this in mind I suggested to the Registrar that he report the proceedings of each meeting shortly after it was held and in this Review. Dr. Campbell expressed himself as heartily in favour but said that some years ago, when a similar proposal was made, the then Council rejected it saying that their business should not be given publicity. It is quite true that, on occasion, matters come up for discussion that should not see the light of print, but there is no matter discussed upon which we should not be informed and in a fuller way than can be done in a brief annual report. Theoretically at least the Council speaks with our voice and actually we are bound by its decisions. It is more than likely that open discussion by the profession in the role of members of the College would be useful and profitable. For example there is the matter of the funds which now stand at \$64,000. It is inconceivable that the time will ever come when such a large sum of money would be required to defend or protect our rights. At present it is invested in bonds but it could be more profitably invested, one might think, in the medical youth of the province as in prizes, bursaries or scholarships; or in the supplying of equipment to the Medical School; or in furnishing the Library with the means of procuring some of the many books which it needs but cannot afford. One small expense is long overdue and that is the publication of a Medical Register. The last is dated 1930 and has not been kept up to date, although scores of changes have occurred since then. Mr. Whitley, who looks after the Social Page, gathers much of his material from newspaper items. He tells me that it is exceedingly

difficult for him to find out whether any particular doctor is a Manitoba man or even if he is an M.D. Thus recently he inadvertently extended our congratulations to a chiropractor on the birth of a child! Not that we have any objections to chiropractors indulging in the laudable and time-honoured practice of raising families but you must admit that it is a bit embarrassing to have a chiropractor thank you for singling him out for mention in our select and exclusive journal, especially when we are not really interested in his procreative activities.

Returning to our main theme I think that it would be a desirable and profitable innovation if the Council were to hold at least one open meeting each year. It would give us, among other things, an opportunity of recalling who represent us and who is our President, information which, I am inclined to believe, few of us could furnish off-hand. One would also like to know what happened to the movement afoot some years ago, for the fusion of the College and the Association. That arrangement seems to have worked very satisfactorily in the western provinces; might it not be well to think of its application here?

♦

### The Writers

#### K. J. Backman, M.D.,

Director of Venereal Disease Control for Province of Manitoba.

#### H. D. Kitchen, M.M., M.D., C.M.,

Associate Professor of Medicine, University of Manitoba. Acting Head of the Department of Medicine, University of Manitoba. Associate Physician, Winnipeg General Hospital.

#### J. C. Hossack, M.D., C.M.,

Assistant Professor of Medicine, University of Manitoba. Associate Physician, St. Boniface Hospital.

♦

### Obituary

Narcisse Albert Laurendeau, M.D., died in St. Boniface Hospital on September 4, aged 61. Born in St. Boniface, he was educated in Provencher School and St. Boniface College. His medical education was obtained at Manitoba Medical School and Laval University, where he graduated in 1909. He practised continuously in St. Boniface, which city he served as mayor for two years and coroner for fifteen years. Three daughters and two sons survive him.



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The average daily dose of Vi-Daylin for infants is one-half to one teaspoonful, depending on age and condition. One teaspoonful, 5 cc., supplies at least twice the minimum daily requirement for infants of vitamins A and D and riboflavin, at least three times that of vitamin B<sub>1</sub>, four times that of vitamin C, and the recommended daily allowance of nicotinamide.

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Vitamin A.....	5000 Int. units
(from fish liver oils)	
Vitamin D.....	1000 Int. units
(Viosterol)	
Thiamine Hydrochloride.....	1.0 mg.
(Vitamin B <sub>1</sub> , 266 Int. units)	
Riboflavin (vitamin B <sub>2</sub> ).....	1.5 mg.
Ascorbic Acid.....	75 mg.
(Vitamin C, 1500 Int. units)	
Nicotinamide.....	5 mg.

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## Personal Notes and Social News

Dr. Thos. A. Lebbetter, recently demobilized from the R.C.A.M.C., has joined the staff of the Winnipeg Clinic as associate Medical Director. Dr. Lebbetter was one of the leading internists in Nova Scotia, also past President of the Nova Scotia Medical Society.

Lieut.-Colonel C. W. Clark, formerly with the R.C.A.M.C., has returned to his surgical practice in association with the MacCharles Surgical Clinic, 216 Medical Arts Building.

Dr. and Mrs. J. S. Hollowin are happy to announce the birth of their second daughter (Jo-Ann Carol) on September 15th, 1945, at St. Boniface Hospital.

Colonel R. W. Richardson, O.B.E., has been demobilized from the R.C.A.M.C., and has now resumed practice at his former office, 105 Medical Arts Building.

Dr. John Webber Bawden, son of Mr. and Mrs. J. W. Bawden, of North Battleford, Sask., was married September 29th to Audrey Beatrice, daughter of Mr. and Mrs. Forbes of Dauphin, Man.

Colonel W. L. Fennell (U.M. "34"), M.D., R.M.S., O.B.E., was a recent visitor to Winnipeg, where he renewed acquaintances with his many old friends. Col. Fennell has spent the last ten and a half years abroad; three in England and seven and a half in India. He is returning to India at the end of October.

Captain and Mrs. Donald J. Hastings, R.C.A.M.C., wish to announce the birth of a son (Michael Charles) at the Winnipeg General Hospital, on September 30th, 1945.

Lieut.-Colonel John Hillsman, R.C.A.M.C., has resumed the civil practice of surgery at 308 Medical Arts Building.

Dr. and Mrs. Barrie Duncan and family, of Winnipeg, have left to make their home in Dawson City, Yukon Territory.

Dr. C. C. Henneberg, recently demobilized from the R.C.A.M.C., is now practicing at 302 Medical Arts Building.

Colonel Gordon S. Fahrni, formerly consulting surgeon, Canadian army, has resumed practice in general surgery at his former office, 105 Medical Arts Building.

Dr. Robert Swan has taken up practice at 215 Medical Arts Building.

Dr. M. Rodin, R.C.A.M.C., youngest son of Mrs. B. Rodin and the late Mr. Rodin, is engaged to marry Rowena, only daughter of Mr. and Mrs. M. Waldman, of Winnipeg.

Dr. Julius Anderson, formerly with the armed forces, is now practicing at 185 Maryland St.

Dr. Frank Paulson has joined the staff of the Winnipeg Clinic.

Dr. Leslie Pittar Lansdown has been demobilized from the R.C.A.M.C., and is now practicing at Pine Falls, Man.

Major Joseph Robert Campbell, formerly of the Mayo Foundation, Rochester, Minn., was awarded the Bronze Star recently and an Oak Leaf cluster to the Bronze Star. Both citations read, in part, "for meritorious and direct support of combat operations." Dr. Campbell is division psychiatrist for the 3rd Infantry Division, United States army in Germany.

Dr. Daniel G. Revell, formerly with the R.C.A.M.C., is now on the staff of the Winnipeg General Hospital.

Dr. R. B. Collins, municipal doctor for the rural municipality of Minto, resigned that position on September 30th.



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This noteworthy new preparation fulfills the requirements of possibly the most serviceable type of "ear drops." It is *effectively* antibacterial, analgesic, hypertonic, yet non-irritating.

White's Otomide is a stable solution containing:

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Sulfanilamide	5%
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Glycerin (high sp. gr.)	q.s.

The advantages of carbamide-sulfonamide in topical treatment of localized infections are established.<sup>1,2,3</sup> Carbamide (urea) alone has been successfully used in acute and chronic middle ear disease.<sup>4,5,6</sup> Its association with sulfonamide enhances antibacterial activity, inhibits sulfonamide-antagonists present in purulent exudates. Chlorobutanol is included for its analgesic and antipruritic properties.

**NOTE:** Sulfanilamide has been selected as the sulfonamide of choice because of its greater solubility in tissue fluids, and because "(it) diffuses more rapidly . . . (and) appears to be the least harmful of the commonly used sulfonamides to regenerating tissue."<sup>7</sup>

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Liquid Arsenicalis BP.....2 minims  
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Phenolphthalein..... $\frac{1}{4}$  grain

## **No. 2 TONIC**

Blaud 2 pill—10 grs. Blaud.....2 grs.  $\text{FeCo}_3$   
Liquid Arsenicalis BP.....2 minims  
Extract Nux Vomica Sicc. BP..... $\frac{1}{4}$  grain

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Blaud 3 pill—15 grs. Blaud.....3 grs.  $\text{FeCo}_3$

*Haemo-Ferrin Capsules are available in packages of 100 and in bulk quantity.*

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## Book Review

**Essentials of Body Mechanics in Health and Disease.** By Joel E. Goldthwaite, Lloyd T. Brown, Loring T. Swain and John G. Kuhns. With a chapter on the heart and circulation as related to body mechanics by William J. Kerr. 337 pages. 118 illustrations. Fourth edition. Montreal, J. B. Lippencott Company. \$6.00.

This is a book written by orthopedists but addressed to doctors generally. Curious as to why similar treatment in apparently similar cases (especially arthritis) at times succeeded and at times failed, the authors, after following many blind channels finally determined that the cause lay in structural differences in the patients. This led them to investigate very thoroughly the anatomical arrangement of every patient. Soon they came to the conclusion that the mechanics of the body plays a most important part in maintaining health and that faulty mechanics is a potent factor in causing and maintaining chronic disease. "An individual," they say, "is in the best health only when the body is so used that there is no strain on any of its parts." Yet, while this is only common sense, most of us make no serious effort to remedy such defects as we see in our patients, an omission which is largely due to our failure to recognise their importance and the need for their correction. A reading of this book will quickly change one's attitude towards such physical faults.

The authors describe three body types. Each, it is shown, in its own particular way modifies the posture, the visceral arrangements, the physiological functioning and the predisposition to disease. Even the moderately observant are aware of the relationship between certain builds and certain diatheses. Here this relationship is given prominence and explained. Changes in the structural pattern of the body profoundly influence the structures which the bones support and enclose. To make this clear the roles played by the bones, muscles and ligaments are carefully described, both when their arrangements are ideal and when they are faulty. In the latter case the effect of faulty mechanics upon the viscera are made more clear by diagrams and photographs. The effects of developmental deformities are described in a separate chapter. "Backache and Other Spinal Strains" is the title of a most helpful section.

The thoracic and abdominal viscera are unlikely to function normally if the supporting and containing structures are in faulty alignment. The effect upon the heart is especially important considering how commonly heart disease and

faulty body mechanics are associated. Sagging of the diaphragm and distortion of the thoracic cage increase the load upon the heart and impair its function. Some pages are devoted to this topic and in addition there is a chapter by Professor William Kerr of the University of California entitled "Angina Pectoris and Postural Emphysema Related to Obesity". This is an excellent consideration of the relationship between heart pain and overweight. The physiological handicap laid upon the heart by overweight is very great and is applied in several ways. Obesity is not merely a discomfort but is the begetter of many ailments easier to prevent than to cure.

The normal functions and health of the abdominal viscera depend upon the positions of the diaphragm and abdominal muscles. Faulty mechanics alter these positions, displace and distort the organs, impede the flow of returning blood, and cause discomfort first, then disturbance of function and ultimately actual disease. Just how much can be accomplished by the correction of faulty mechanics in patients with chronic intra-abdominal ailments is illustrated in a series of case histories. Wherever there are mechanical imperfections there are indications for their correction and when that is accomplished the patient's comfort is increased and his ailment symptomatically improved. This applies to disorders of all systems and to patients of all ages. There is a section on chronic arthritis. The chapter on treatment discusses education, exercises and apparatus. There is a chapter on the types, signs and treatment of disabilities of the foot; one on the public health aspects of body mechanics and one on the improvement of defects in the aging and aged.

The book contains 337 pages including 11 pages of index. The illustrations are many and good. The instructions given are clear and simple. It is quite apparent that we are not doing all that can be done for our chronic cases unless we pay attention to the mechanical faults they reveal. Nor are we thorough in our practice of prevention if we permit the development of preventable errors. Correction of faulty mechanics not only improves health but it prolongs life. It requires, however, not merely a knowledge of technique but a good deal of patience on the parts of both doctor and patient. This book should find a place in every doctor's library, and, in accordance with the suggestion I made in the September issue, I recommend it as your book of the month.

J. C. H.

## Manitoba Medical Association Committee Reports

### Report of Executive Committee

*To the Executive and Members of*

*The Manitoba Medical Association:*

Your Executive Committee begs to submit the following report for the year 1944-1945:

During the session nine meetings were held, each very well attended. Many problems were discussed here, the chief being the announcement by the Minister of Health and Public Welfare of a proposed Health Plan to be set up under the Department of Health for the Province of Manitoba.

The proposed plan was first presented to a full meeting of the Executive by the Minister and his Deputy on Saturday evening, January 8th, 1945. The plan was presented under four broad heads:

1. Prevention of Disease;
2. Diagnostic Facilities;
3. Curative Medicine;
4. Hospitalization.

The Minister and his Deputy each explained fully the four parts of the plan and the Government's stand in attempting to implement each separate part. There was full and free discussion, limited only by our unpreparedness as the Executive was hearing the plan for the first time.

A short time later the Minister spoke over the radio and outlined again these same proposals.

The Executive appointed a committee to study this plan. On two subsequent occasions the executive met the Minister and his Deputy and differences of opinion were expressed and discussed so that a few changes were made by the Minister before presenting the plan to the Legislature.

On May 20th, 1945, the Minister entertained the full Executive and several other representatives of interested groups to dinner. This group later met in the Legislative Buildings and discussed again the new Act.

The Health Services Act was finally passed in the local legislature this spring. The Act is administered by the Minister of Health. However, he has an Advisory Commission composed of members from interested groups. The Manitoba Medical Association members are Doctors A. Hollenberg, H. S. Evans and F. G. McGuinness.

Literature from the Department of Health and Public Welfare is available to all and is well worthy of study.

This year a Basic Science Bill was introduced and passed the local house. This bill makes it illegal for any one to practice the healing art without showing his or her competence in certain of the basic sciences, including pathology.

A bill also was passed to license chiropractors who were able to show satisfactory standing in the basic sciences.

*Constitution:* The new Constitution and By-laws referred to this Executive by the last Annual Meeting was finally passed and is to be printed.

*Workmen's Compensation Board:* The Workmen's Compensation Act was reviewed in the Legislature this year, as is done every five years. Two committees of the Manitoba Medical Association dealing with Workmen's Compensation Board activities were unified for the purpose of studying the Act and they were empowered to employ legal counsel if needed.

The Act was not materially changed but the section dealing with the rendering of accounts was amended to allow a time lapse of twelve months, instead of six, during which an account might be sent in.

*Canadian Medical Procurement and Assignment Board:* This committee continued its function until January, when it was felt that, as the end of the war seemed to be in sight, the Canadian Medical Procurement and Assignment Board of each district should administer the process of rehabilitation in the appropriate area. The Chairman of this committee, Dr. F. G. McGuinness, will, no doubt, report on this new phase.

*Firefighters' Club:* When the time came for the annual renewal of this contract the Executive felt that, as the Manitoba Medical Association was giving support to the Manitoba Medical Service, it was not practical to carry on a separate scheme and, therefore, the contract was not renewed. The arrangements with the Firefighters being discontinued on June 30th, 1945, the Firefighters were advised to look to the Manitoba Medical Service for medical care if they so desired.

*Secretary:* For some years the advisability of having a full time or part time paid Secretary has been felt. This year a small committee was formed to study ways and means of obtaining this. It is to be hoped that some definite solution will soon be found because the interests of the profession need constant watching.

*Municipal Doctors:* Through the foresight of Dr. D. C. Aikenhead, the Municipal Doctors were approached with a view to organizing themselves similar to the Health Officers' Association. After some correspondence the Municipal Doctors did meet and the Executive have since written asking that they form a group and then make formal application for affiliation with the Manitoba Medical Association.

Respectfully submitted.

Stuart Schultz,

President.

D. L. Scott,

Secretary.

### Report of Editorial Committee

*To the President and Executive of*

*The Manitoba Medical Association:*

Since last submitting a report of this Committee's activities we have published 12 issues of the Review. In size the Review has increased from 410 pages to 539; 129 more than in the previous year. We have published 41 articles by 31 authors. Two short series, one on Allergy by Dr. C. H. A. Walton and one on Radiology by Dr. H. M. Edmison, was well received. We hope to continue both later. The Hospital programmes covered 64 topics and short abstracts, gave useful information on 64 conditions. This record is good enough for the past year but will not satisfy us for the year just opening.

We wish to thank our contributors. We are particularly indebted to Dr. D. C. Aikenhead who has been responsible for the Winnipeg General Hospital luncheon reports and to the late Dr. A. L. Shubin whose assistance in the luncheons of other hospitals was very great and whose loss we feel deeply.

Thanks are due to Mr. Whitley for his energy and enthusiasm in the technical production of the Review and in the securing of advertising; to the advertisers who make the Review possible; to the printers, Roscoe and Hickson and to Miss Helen Brown who has cheerfully accepted an additional load to her already busy days. We must also thank our readers for their comments and encouragement.

Respectfully submitted.

J. C. Hossack,

Chairman.

## Statement of Revenue and Expenditures

January 1st to August 31st, 1945

## REVENUE

By Fees collected:

Refund from C.M.A. on 1944	
Fees .....	\$ 393.50
5 members at \$5.50 (combined fee) .....	3,296.00
412 members at \$8.00 .....	27.50
	<u>\$3,717.00</u>
Less 1945 fees of 7 members paid in 1944 .....	56.00
	<u>\$3,661.00</u>
Interest on Bonds .....	172.65
Winnipeg Medical Society .....	280.00
Exhibitors—Annual Meeting .....	225.00
Canadian Medical Procurement and Assignment Board .....	163.92

## EXPENDITURES

To Bank Charges, Exchange, etc. ....	\$ 22.60
Executive Luncheons .....	11.50
General Expense:	
Telephone .....	\$ 79.05
Bond on Treasurer .....	5.00
Business Tax .....	20.06
Advertising, demobilized doctors .....	94.50
New typewriter—two-thirds Interest .....	118.75
Feldsted Gold Medal and Tax Copyright—Manitoba Medical Review .....	3.00
Legal Opinion re Income Tax .....	10.00
Legal Fees re Workmen's Compensation Board Act .....	50.00
Servicing Typewriter .....	7.00
Court Reporter Attendance Winnipeg Medical Meeting re Health Services Act .....	48.75
Wreaths .....	5.00
Miscellaneous .....	8.78
	<u>487.39</u>
Printing, Postage and Stationery .....	148.64
Rent .....	224.00
Salaries:	
H. M. Brown .....	\$1,000.00
E. Prest (extra help) .....	60.00
Unemployment Ins. Stamps .....	11.34
Dr. J. C. Hossack—Honorarium .....	275.00
	<u>1,346.34</u>
Travelling Expenses—President's attendance C.M.A. Annual Meeting .....	155.80
	<u>\$2,396.27</u>
	<u>\$4,502.57</u>
	<u>2,396.27</u>
By Surplus of Revenue over Expenditures .....	<u>\$2,106.30</u>

## COMMITTEE ON SOCIOLOGY

January 1st to August 31st, 1945

Balance in Bank of Montreal as at December 31, 1944 \$397.06

## REVENUE

By Interest on \$2,000.00 Dominion of Canada 3% Bonds .....	30.00
5% deductions made from Relief Accounts paid to Doctors and received by Sociology Committee, as follows:	
Municipality of East Kildonan .....	13.95

## EXPENDITURES

To Solicitor's Fee—Collection Dr. J. J. A. Bourgouin's Account re Felix Lamoureux Case .....	\$20.00
	<u>\$20.00</u>
	<u>\$441.01</u>
	<u>20.00</u>
Balance in Bank of Montreal as at August 31, 1945 .....	<u>\$421.01</u>

Respectfully submitted.

A. M. Goodwin,  
Treasurer.

## Report of Committee on Legislation

To the President and Executive of  
The Manitoba Medical Association:

As chairman of this standing committee, I have to report to you as follows:

During the year past the committee had to deal with only one subject of importance.

As you know, the Chiropractors of the province wished to introduce certain legislation which would have greatly benefited themselves. Our committee held numerous meetings concerning this legislation. Also, meetings with our solicitor and with the Minister and Deputy Minister of Education.

After very careful consideration we felt we could not successfully combat the Chiropractors in the legislature and felt it would be better to try and control, rather than make a head-on battle, and with this in view we were successful in securing from the Government what is known as the Basic Science Law. The provisions of this act, I think that probably all the members are familiar with.

In securing this law it was necessary to give the Chiropractors certain privileges under an act of their own, but as it now stands anyone wishing to practice in the province must measure up to the provisions of the Basic Science Law, and we felt this would take care of the Chiropractors in Manitoba.

I think that is really all.

Respectfully submitted.

C. R. Rice,  
Chairman.

## Report of Cancer Committee

To the President and Executive of  
The Manitoba Medical Association:

During the past year the Manitoba Cancer Institute, in addition to maintaining its radium facilities and its X-ray Therapy Department, located immediately adjacent to the Winnipeg General Hospital, has extended its patient follow-up service to cover not only all patients treated in its own Department but all cases of malignancy in hospitals in the Greater Winnipeg area.

The lay educational activities of the Institute have been accelerated. Co-operation has been extended with the Canadian Cancer Society, which is a Dominion body interested in the same field of work. The Manitoba Cancer Institute is doing the work for this Society in Manitoba in addition to its own activities. The rural biopsy service has shown a very pleasing increase in utilization. For the year ending April 30th, 1945, there were 360 biopsies, as compared to 306 for the previous year, and 199 for the year before that.

All of which is respectfully submitted.

A. M. Goodwin,  
Chairman.

## Report of Manitoba Divisional Advisory Committee, Canadian Medical Procurement and Assignment Board

To the President and Executive of  
The Manitoba Medical Association:

With the cessation of hostilities the work of this Committee should largely be reduced to rehabilitation.

(a) *Post Graduate Studies:* Doctors Frank Patch, John Fraser and George Stephens, representing the Royal College of Physicians and Surgeons, the Association of Medical Colleges and the Hospitals of Canada, were formed a sub-committee of the Central Board with a view to planning refresher courses and post-graduate instruction for upward of 4,000 medical officers.

This committee has done a great deal of work in association with the body they represent. The committee has arranged in booklet form a syllabus of refresher and post-graduate opportunities which has been compiled for the benefit of demobilized medical officers. This booklet has been sent to all Canadian Medical Officers in His Majesty's Services in order that they may acquaint themselves with what is available and under what terms and conditions, as set down by the Act of Parliament.

(b) *Placement—Establishment and Re-establishment:* The absorption of some 4,000 doctors back into civil life is a matter of great concern, both to the doctor and the nation. Some 50% of these doctors have never been engaged in private practice and have no position awaiting their return. Approximately 50% have a practice to which they eagerly await the opportunity to return or, perchance, wish to seek new fields.

In anticipation of this situation, a National Health Survey was conducted by the Board of the nine Divisional Advisory Committees and the report published by the Government. Since the publication of this report an attempt has been made to keep it up-to-date. By card registers the names of all Canadian doctors, both within and without the Services, have been compiled, i.e. where they are, the areas they serve, the areas now without doctors and the possibilities of practice in every part of Canada. This information is available for any medical man that wants it.

*Secondment to Rural Areas:* By virtue of an agreement entered into between the Federal and Provincial Governments, the Canadian Medical Procurement and Assignment Board was authorized to recommend the secondment of medical officers to rural areas and Departments of Health which, in the opinion of the Board, Provincial Department of Health and the local Division Advisory Committee, were badly in need of medical services. The medical officers so seconded were to hold the rank of Major (or its equivalent) to receive full service pay and allowances, necessary office facilities, transportation and drugs. In other words, their income was net, save cost of house rent. Any money collected by the serving medical officer was to be turned over to the local municipality.

Furthermore, with the launching of this plan, public criticism which has been levelled against the profession for its inability to provide needed medical care to rural areas largely faded out.

In submitting this report I wish to pay tribute to all the members of the Committee who have given so generously of their time during the last four years.

All of which is respectfully submitted.

F. G. McGuinness,  
Chairman.

## Report of Membership Committee

To the President and Executive of  
The Manitoba Medical Association:

As at August 31st, 1945, of the 469 doctors practicing in the Province of Manitoba 416 are active paid-up members,

7 are honorary and 2 are associate members of the Manitoba Division of the Canadian Medical Association, which constitutes a total membership of 90%. A breakdown of these figures shows that of the 314 City of Winnipeg physicians 277 are active members, while of the 155 physicians in the country 139 are active members. This is an increase of 22 members in the Province over last year's total membership of 394.

During the year 48 new members have been enrolled; 16 members have been lost to us, 9 of whom are deceased, 4 have left the Province and 3 have retired.

Twenty-six doctors have returned to civilian practice from the Armed Services and we are happy to announce that, in accordance with a resolution passed by the C.M.A. Executive,

"THAT, upon receipt of advice from a Division that a demobilized doctor has been granted free membership in that Division for a period to include one full calendar year following his demobilization, the C.M.A. will grant that member free membership for the same period, including the Journal"

the Manitoba Division of the C.M.A. will extend free membership to all returned medical men, registered, or who become registered, in the Province of Manitoba.

Our sincere thanks is extended to all those members of the Manitoba Division who have assisted in attaining our membership.

All of which is respectfully submitted.

A. M. Goodwin,  
Chairman.

## Editorial Board of C. M. A. Journal

To the President and Executive of  
The Manitoba Medical Association:

The Editorial Board of the Canadian Medical Association Board begs to report as follows:

The following Manitoba physicians have contributed scientific papers to the C.M.A. Journal: A. C. Abbott and Earle Stephenson, J. D. Adamson and collaborators, D. C. Aikenhead, S. S. Peikoff, Anna Wilson and K. R. Trueman, F. F. Miles and Digby Wheeler, F. G. Stuart, J. P. George, Murray Campbell, A. P. Guttman, C. M. Thomas, A. Hollenberg, L. A. Sigurdson. The Medical Survey of Nutrition in Newfoundland by Lt.-Col. J. D. Adamson and associates is a particularly fine report on nutrition in that colony under wartime conditions.

2. Manitoba news items were contributed monthly.

3. Obituary notices of Manitoba physicians have been sent to the editor.

4. The editor, Dr. H. E. MacDermot, welcomes case reports.

Respectfully submitted.

Ross Mitchell,  
Chairman.

## Extra Mural Committee Report

To the President and Executive of  
The Manitoba Medical Association:

Due to war conditions, the Extra Mural report is very short this year. Two meetings were held:

Lt. Col. C. W. Clark spoke on May 3rd, 1945, at Morden, and on May 16th, 1945, he again spoke at Neepawa. Colonel Clark, on both occasions, gave a most interesting and clear review of certain surgical experiences overseas.

It is to be hoped that now hostilities have ceased the extra mural services will be elevated to its pre-war value.

All of which is respectfully submitted.

N. L. Elvin,  
Chairman.

## Report of Manitoba Medical Service

*To the President and Executive of*

*The Manitoba Medical Association:*

About four years ago the Manitoba Medical Association appointed a committee to bring into being a Health Insurance Plan in Manitoba. The motives prompting this action were three:

1. To gain information on methods and costs from our own experience and in our own community;
2. To meet at least in part a desire of the public for pre-payment of health costs;
3. To possibly forestall government entry into this field with a plan we thought unsuitable.

To Dr. H. D. Kitchen, the then President, belongs the major credit for this step and it is obvious now how wise a step it was.

Arrangements had been made by the Manitoba Medical Association to provide funds for organization expenses. They, themselves, subscribed \$1,000.00, the Winnipeg Medical Society \$500.00, and the College of Physicians and Surgeons \$5,000.00, giving us a total of \$6,500.00 for that purpose.

The first decision the committee made was that, if a Health Insurance Plan was to be inaugurated in Manitoba, it should be done gradually and it seemed feasible to commence within the area of greater Winnipeg. This having been decided, the whole practising profession of that area was circularized to see if they were willing to practise under a Health Plan. The response was surprising in that over 90% expressed their willingness to do so. Taking this as an indication that we should proceed, we began laying our plans.

One of the first problems we considered was the approach to the public. It seemed impractical for various reasons for us to set up a sales organization of our own. The Manitoba Hospital Service Association came into the picture here. They were interested in getting a Health Insurance Plan in operation to supplement their Hospital Insurance. They already had a sales organization and a system of collection by payroll deductions. After considerable thought and discussion, your committee decided that, for the first year at least, we might restrict the sale of our medical prospects to employed groups who already had hospitalization insurance. This involved dealing with a section of the population that excluded the very low income group who were not able to afford hospitalization and possibly some of the very high income groups who felt they did not need insurance to pay their hospital bills. A large percentage of the people who held hospital contracts were from the medium income groups. It was obvious that the M.H.S.A. could sell our contracts and collect the premiums through their organization much more cheaply than we could, and it was a distinct advantage to have them handle that part of the work.

Tentative plans along this line having been made, we next applied ourselves to the task of drafting a private bill of incorporation of the Manitoba Medical Services Association for submission to the Legislature. For our guidance, we employed the services of the late Mr. W. C. Hamilton, K.C., who happened to be the legal advisor of the M.H.S.A. and had prepared their legislation. The preparation of this bill required considerable planning and discussion. We decided that two plans of Health Insurance should be available—Plan A (the partial plan) including Surgical and Obstetrical Services in Hospital only, and Plan B (the complete plan) including a full health service, except for Statutory exemptions, (Mental and Venereal Diseases, Alcoholism, Drug Addictions, etc.). The details of these plans were set out. The contract with the patient and the contract with the medical members (doctors) were also prepared.

In the preparation of these various plans and contracts the general profession on three occasions was consulted and further instructions were received. As can readily be imagined, considerable difference of opinion existed on various points. Our original committee of eight members had done a large amount of work on the problem and it was thought advisable to add

a further eight members to help us complete the proposed bill. The new group were a very great help. They reviewed what had been done, brought in new ideas and, finally, we thought that we had a satisfactory bill prepared. The bill was submitted to the Legislature and became law on March 31, 1942. One of the most important points in the bill was the composition of the Board that was set up to control the new organization. The Board consists of 21 members, 14 of whom must be doctors and 7 laymen, all appointed for a period of three years. These 14 doctors must be members in good standing of the Manitoba Medical Association. The laymen have been selected from various public groups. The doctors who are members of the Board are nominated by the Manitoba Medical Association and then appointed by the Board. The Board has the privilege of appointing members on its own to fill a vacancy, but this member may only complete the term of the previous member whose place he took.

In regard to the financial arrangements that were made covering the cost of the medical services to the patient, and the remuneration of the doctor, I wish to be particularly clear. The costs to the patients (premiums) were recommended by the Committee on Economics of the Manitoba Medical Association and our Board raised their figures by 20%. The remuneration to the doctor is based on a schedule of fees adopted by the M.M.A. The Board takes no responsibility in setting up a fee schedule, except for items not included in the M.M.A. schedule, and these are tentative only. Following the plan of the Firefighters Medical Service and the Relief Plan, it was agreed that specialists would receive a bonus of 25% over the fees allowed to the general practitioner. The fee schedule prepared by the M.M.A. is based on the fees of a general practitioner. No fee schedule for specialists has been submitted by the M.M.A.

In regard to medical practise within the plan, each medical member (doctor) was asked to signify the type of practise he wished to do. If he elected to practise as a specialist he would be paid a bonus of 25% but must confine his practise to that field. This rule has been relaxed slightly recently so that a medical member may choose a major and minor specialty, get a bonus in the major specialty but general practitioner's fees in the minor. Some Board members feel that restricting a specialist to his own field absolutely is working an injustice on him and are planning to bring this point up for general discussion at this meeting.

Following the passing of the bill by the Legislature, there was considerable delay in implementing the service. There were several reasons for this, the main one being the possible imminence of the National Health Insurance Plan. However, about July, 1944, the sale of contracts was started and Medical service inaugurated on October 1st, 1944. The services of Dr. E. S. Moorhead were obtained as Medical Director. He very generously asked for a part-time salary during the early months although there was a great deal of work to be done. The plan has been in operation for nearly a year.

I am including in this report the financial statement from October to December, 1944, and a synopsis of our monthly statements for 1945 to date. A copy of our audited annual statement will be sent when it is complete.

### *Medical Contracts:*

Contrary to experience elsewhere, Plan B, for complete medical service, has far outsold Plan A, 87-13. At the end of July, 1945, we had over 19,000 insured people, 2,570 in Plan A and 16,485 in Plan B. The M.H.S.A. is pleased with the success of that phase of the plan.

### *Costs of Administration:*

The costs of administering the plan are satisfactory, varying from 14-22.4% this year. It is expected these percentage costs will come down as the number of subscribers increases.

### *Financial Returns to Medical Members:*

It has been the universal experience in starting these Health Plans that the first two years were the heaviest. This is to be expected because we are dealing with small numbers of patients in the early stages, and more so because many patients, antici-

pating the benefits of the plan, sometimes by months or even years, delay medical attention until they have their Health Insurance, and then crowd in. During the seven months of 1945 we have been able to pay approximately 65% of our schedule of fees. The M.H.S.A. tell us the first six months of the year are always their worst. If this holds for medical services, we would be able to pay a higher percentage than 65% for the balance of the year.

In making these payments to medical members we have adopted the principle that the member getting small fees should get a higher percentage of his fee than the one receiving large fees. We began by paying all fees up to \$10.00 in full and discounting the ones above that, but none were discounted below \$10.00. In applying this rule to the accounts presented, we found that some members were getting as high as 95% of their schedule fee and others as low at 55%. This seemed unfair and we are trying other formulae with the hope of getting a more equitable distribution.

The unpaid balance is being carried as a credit to the medical member. The future value of these credits is unpredictable. It is our intention to review them at the end of the current year and, if possible, adjust them. It may be that in later years a surplus will be available and, if so, partial payments may be possible. The donations from the College of Physicians and Surgeons, the Manitoba Medical Association and the Winnipeg Medical Society are being carried as contingent liabilities that are to be refunded if, as, and when possible.

#### The Future:

Whether this Association shall go on depends on its ability to provide satisfactory medical service which rests entirely with the medical members, and on its ability to provide a reasonable return to the profession for services rendered. We have reason to believe that the professional services rendered are pretty satisfactory. The premiums charged to subscribers may be too low, but it is too early now to decide. The fee schedule of the Compensation Board was based on two-thirds of the Manitoba Medical Fees. Our Association is paying this year almost that much. It is quite possible that we may have to raise the premium, at least for some of the contracts, before very long and there is no reason why this cannot be

done. If the returns to the profession turn out to be too low, the only way of raising them is to raise the premiums.

If National Health Insurance is brought into force (and at the moment it seems very likely) it will be administered by the provinces. If the Provincial Government operates a national plan within the province they may set up an administration of their own or, as an alternative, operate the medical part of it through the M.M.S.A.

No attempt has yet been made to include non-employed people in our subscribers, nor to set up a similar plan in rural areas. The latter has been discussed and could be done if both the profession and the public in an area wished it to be done.

#### Conclusions:

Your committee has carried out your wishes and inaugurated a Health Insurance Plan in Greater Winnipeg.

The professional services under the plan are satisfactory.

The cost of administration is satisfactory.

The financial returns to those rendering the service cannot be appraised as yet.

The whole undertaking should be viewed as an experiment in medical practise under an Insurance Plan of pre-payment, the profession in the meantime taking the loss, (as we always do in our private practise). This loss, which is the difference between what we do get and what we would get if every patient paid 100% of the schedule fee (which never happens) may be one of the best investments we ever made.

I wish to thank all members of the committee who have been most generous of their time and energy, and particularly the lay members, Mr. R. B. MacKay, Mr. J. B. Richardson, Mr. M. D. Grant, Mr. F. W. Ross and Mr. E. Jones. These gentlemen have maintained interest in our organization for years, have always been punctual and so helpful that, without their advice and guidance, we would have fallen into many more errors.

Attached statement from October to December, 1944.

Attached summary from January to July, 1945.

All of which is respectfully submitted.

M. R. MacCharles,  
Chairman.

### MANITOBA MEDICAL SERVICE ENROLMENT

PLAN "A"			PLAN "B"		
1945:	Subscribers	Dependents	1945:	Subscribers	Dependents
January .....	843	717	January .....	3,368	4,488
February .....	928	784	February .....	3,745	4,909
March .....	1,156	960	March .....	4,415	5,729
April .....	1,232	1,031	April .....	4,983	6,426
May .....	1,281	1,047	May .....	5,438	7,018
June .....	1,367	1,113	June .....	6,546	8,437
July .....	1,423	1,148	July .....	7,235	9,250

### ENROLMENT BY GROUP AS AT JULY 31, 1945

#### Plan "A"—

Male and Dependents .....	543 Male	539 Females	277 Male Child	290 Female Child
Female and Dependents .....	—	23 Females	17 Male Child	25 Female Child
Single Male .....	166 Male	—	—	—
Single Female .....	—	685 Females	—	—
Sponsored .....	—	6 Females	—	—

#### Plan "B"—

Male and Dependent .....	3,716 Male	3,685 Females	2,790 Male Child	2,566 Female Child
Female and Dependent .....	—	113 Females	85 Male Child	91 Female Child
Single Male .....	880 Male	—	—	—
Single Female .....	—	2,444 Females	—	—
Sponsored .....	13 Male	69 Females	—	—
Military .....	—	14 Females	14 Male Child	5 Female Child

## CLAIMS

1945:	Claims	Amounting To	Average Cost Per Claim	Payment Made	%
January .....	1,093	\$12,168.75	\$11.13	\$ 8,342.82	68.6%
February .....	1,100	13,444.00	12.22	8,915.32	66.3%
March .....	1,339	15,325.25	11.44	10,281.74	67.1%
April .....	446	5,482.25	12.29	3,584.80	65.4%
May .....	1,947	22,808.75	11.71	15,139.67	66.4%
June .....	2,236	24,501.30	10.95	17,814.82	72.9%
July .....	2,006	23,471.75	11.70	14,996.96	63.9%

There are 252 doctors enrolled — of these 91 are Specialists — 36%.

Specialists receive 46.4% of total Claims amount.

Ancillary Services run approximately 12.4% of total claims.

Laboratory Services .....	There are approximately	115 claims per month	costing approximately \$ 4.61 per claim
X-Ray Services .....	There are approximately	91 claims per month	costing approximately 13.08 per claim
B M R Services .....	There are approximately	6 claims per month	costing approximately 5.00 per claim
E K G Services .....	There are approximately	27 claims per month	costing approximately 5.01 per claim

## MANITOBA MEDICAL SERVICE

1945:	Subscribers Payments	Expenses Administration, Etc.	Operating Expense	Medical Service
January .....	\$ 8,648.92	\$2,200.21	22.94%	118.12%
February .....	9,050.50	1,920.38	16.41%	118.68%
March .....	14,775.25	2,547.31	21.08%	128.76%
April .....	15,210.92	2,324.74	14.08%	121.52%
May .....	16,325.65	3,072.44	18.92%	117.16%
June .....	17,406.12	3,241.69	19.00%	145.07%
July .....	18,736.48	3,414.99	17.76%	149.17%

CLAIMS \$ 5,418.00 COLLECTABLE \$ 7,278.35 PLAN "A" ..... January to June, 1945, inclusive

CLAIMS 88,380.00 COLLECTABLE 72,743.00 PLAN "B" ..... January to June, 1945, inclusive

## MANITOBA MEDICAL SERVICE

## BALANCE SHEET

December 31st, 1944

## ASSETS

Cash:	
Cash at Bank .....	\$ 6,829.69
Accounts Receivable:	
Subscriber Payments M.H.S.A. ....	7,447.43
Deferred:	
Organization Expense .....	3,600.00
	<u>\$17,877.12</u>

## LIABILITIES

Accounts Payable:	
Manitoba Hospital Service .....	\$ 723.33
Sundry .....	665.76
Claims—Physicians and Surgeons ..	13,096.95
	<u>\$14,486.04</u>
Deferred Income:	
Unearned Subscriber Payments .....	1,576.45
Deferred:	
College of Physicians and Surgeons ..	\$ 5,000.00
Manitoba Medical Association .....	1,000.00
Winnipeg Medical Society .....	500.00
	<u>6,500.00</u>

Surplus:  
Operating loss for period ended Dec. 31, 1944 ... 4,685.37 Dr.

\$17,877.12

## STATEMENT OF REVENUE AND EXPENSE

For the period ended December 31st, 1944

Revenue:	Current Month	Year to Date
Subscriber Payments Earned .....	\$ 7,210.48	\$12,739.18
Expense:		
Administration .....	\$ 500.00	\$ 2,000.00
Advertising .....		
Furniture and Fixtures .....		
General Expense .....		79.18
Legal .....		
Postage .....		35.69
Printing, Stationery and Office		
Supplies .....	539.34 Cr.	606.40
Rent .....	133.33	133.33
Salaries .....	765.00	1,198.00
Audit .....	200.00	200.00
Car Expense .....	75.00	75.00
	<u>\$ 1,133.99</u>	<u>\$ 4,327.60</u>
Claims—Physicians and Surgeons ..	8,267.20	13,096.95
	<u>\$ 9,401.19</u>	<u>\$17,424.55</u>
Loss for the Period .....	2,190.71 Cr.	4,685.37 Cr.
Operating Expense .....	15.72%	34.00%
Medical Service .....	114.66%	102.80%
Loss .....	Cr. 30.36%	Cr. 36.80%
	<u>100.00%</u>	<u>100.00%</u>
	<u>\$ 7,210.48</u>	<u>\$12,739.18</u>

SUBSCRIBER PAYMENTS RECEIVABLE \$4,021.30

## Report of Committee on Economics

*To the President and Executive of*

*The Manitoba Medical Association:*

This last year has been one of unusual activity for your committee because of the sudden appearance on the scene of "The Health Services Act" which was passed by the Government of Manitoba in its last session. This act empowered the Provincial Government to set up:

1. *Public Health Units* which would be directly under the Department of Public Health with a local board of supervision. Their function is to care for all measures of Preventive Health, examination of school children and their immunization. There is to be a medical doctor in charge of each unit who is to be a civil servant.

2. *Provision for General Practitioner Service* for any Municipality which desires it, on a basis of payment on a per capita basis, the cost to be divided between the Province and the Municipality concerned. The payment to the doctor is to be on the basis of a per capita cost, or of a salary, or of a fee for service, or any combination of these three upon which the contracting physician and hiring authority agree.

3. *Diagnostic Services*—In each district served by such a practitioner the Provincial Government will supply laboratories and technicians for x-ray, pathological, and biochemical work for diagnostic purposes on a basis which is to be almost free—a small service charge to the patient being envisaged, which will discourage wastage and unnecessary examinations.

Your committee worked many days on the proposals submitted by The Hon. Ivan Schultz and drew up principles which were incorporated into the "Act." There was one contentious point which was dwelt upon by your committee and executive—that was the responsibility of administration. The Minister felt that, as the money was that of the Government and that as he was responsible for it to the legislature, he could not hand the money over to a commission for their administration. A compromise was reached in that an Advisory Commission was set up consisting of eleven members—

- 3 from the Manitoba Medical Association
- 1 from the University of Manitoba Faculty of Medicine
- 1 The Deputy Minister of Health
- 3 from the Union of Municipalities
- 3 appointed by the Lieutenant Governor in Council.

The chairman was to be a layman.

This commission was to advise the Minister in the administration of the Act, could initiate any changes that it desired in the spirit of the Act and that all functions of the Department of Health in the administration of "The Health Services Act" were to be subject to approval by the commission. In other words, the Act could not be implemented or operated except by the agreement of both the Minister and his Advisory Commission. Disagreement on any point would mean a status quo.

With this agreement your committee concurred and the Act was so constructed.

It is to be noticed that the chairman of the above Advisory Commission was nominated by the Minister and is a layman. We felt that as there were five medical men on the commission with five laymen and a lay chairman that organized medicine would be under no handicap in the presentation of its position on the floor of the Commission.

*Contracts for Physicians to be engaged:*

You all have received a questionnaire regarding the vital points to be considered in the drawing up of a contract between a physician and a hiring authority under "The Health Services Act." A good response was received—75% of the questionnaires being returned—and now your committee is in a position to know what the profession desires and considers necessary for its protection in the elaboration of such a contract. It will so act.

*Physicians engaged on full time basis by the Province and City:*

Your committee also felt that it could not protect the interests of those to be engaged by the Province as full time

health officers in charge of the Proposed Health Units without first arranging for a fair contract for those already engaged full time or part time by the Province or a Municipality. Accordingly, a questionnaire was sent to those so employed asking them if they desired the Manitoba Medical Association to act for them with that point in view. About 55% of the questionnaires were returned with a positive answer and in due course a general meeting of those physicians concerned will be called by the Chairman of Economics for the purpose of discussing and implementing the purpose of the questionnaire, i.e. the drawing up of fair conditions of employment—salary—increases—superannuation—post graduate study—and all other conditions which vary in the case of a physician from that of the ordinary civil servant.

*Canadian Medical Association Meeting:*

At the session of the General Council of the Canadian Medical Association last June your chairman reported the enactment of "The Health Services Act" in Manitoba and described its provisions. There was some discussion and criticism on the provision of a commission which was advisory rather than administrative and, further, that the chairman was a layman instead of a medical man, as set out in the principles adopted by the C.M.A. the year before. Your chairman invited any assistance the C.M.A. could give to change this situation.

*Travelling Liaison Officer of the C.M.A.:*

The General Council of the C.M.A. advised the Executive of the C.M.A. that, as legislation was coming up in province after province with a view to providing medical service to the people under provincial government auspices, that a liaison officer of the C.M.A. be appointed who will travel from province to province and assist the local Economics and Legislative Committees in their deliberations with the provincial governments. Such a unifying influence would be a great asset and in Manitoba we did not have the benefit of such a man in our crucial period. Such a man should be one who knows his subject and would command the respect of the members of the profession and the leaders of government.

*Dominion Provincial Conference:*

Since the proposals of the Dominion Government to the Dominion-Provincial Conference have been published, the importance of "The Health Services Act" in Manitoba has been overshadowed. In these proposals the Dominion Government will subsidize each province for the provision of just those services which our "Health Services Act" set out. The costs of the Dominion draft are interesting. They total \$10.10 per annum for the care of each individual for general practitioner, specialist and laboratory services. According to the Manitoba Medical Services, using our own moderate scale of fees, we find it costs \$18.00 per annum for such care if we exclude the cost of administration, and 15% more if we include administration. We are in a position to argue very forcefully regarding these costs because, thanks to the Manitoba Medical Service and the generous financial sacrifice of Winnipeg practitioners, we have had almost one year's operation of a plan which gives total medical coverage to an actuarially representative group of people. If our Manitoba Medical Service has done nothing more than to show what it costs to look after a citizen for one year—it has more than justified its existence.

*The Manitoba Medical Service for use by the Province:*

Your committee believes that the best interests of the people of this province will be served when the province initiates either general practitioner or specialist or diagnostic services—if the money so allocated be vested in the hands of the Manitoba Medical Service for distribution by the Manitoba Medical Service to the practitioners on a basis of fee for service rendered. Further, that the Manitoba Medical Service be empowered to subsidize physicians to settle in areas which have not enough population to attract a medical practitioner and so place the whole onus of satisfactory medical service to the people on the profession of Manitoba. We

must be prepared to take that burden because we can do it better than any governmental agency. It would be only fair to allow proper Provincial Government representation on the Manitoba Medical Service Board. The only fly in the ointment is the cost per person that will be available. There can be no argument on the cost. We have the figures and they are double those proposed by the Dominion Government.

#### *The Manitoba Medical Service:*

The Manitoba Medical Service has done a good job in providing total medical service to the citizens of Winnipeg on a pre payment basis. It has also given us the figures that will enable us to tell government the cost of such care. After one year there are evident statements that must be made by this committee. Firstly, the cost of administration is too high. It has varied from 15% to 19%. A great deal of the cost lies in our association with the Manitoba Hospital Service Association. The auditors are now looking into this abnormal figure. Whatever their findings, this committee feels that 10% would be reasonable. Secondly, we feel that our premiums are too low for the service rendered. A rise in premium of one dollar per month per family for total coverage (\$3.50 to \$4.50) would go a long way to covering the complaints of the profession on the score of reduced fees. An alternative to this would be to leave the premium stationary at \$3.50 per month per family and limit the benefits by excluding diagnostic laboratory services, diagnostic x-rays, and refractions. The patients should pay for these latter services as they are required. It is only by adopting one of these two proposals that the Manitoba Medical Service will continue to get the co-operation of the profession. The argument that the increased volume of work due to the Manitoba Medical Service has no weight now because all practitioners are in a position where they cannot do much more.

#### *Requirements of Practitioners by our Province:*

The number of practitioners in our province now is quite inadequate and, even with the return to practice of those in the Armed Forces, there will be an annual deficit of 25 practitioners. This extra number will be required to give medical service to those parts of the province which should have it but never have had. This increase will also be required to give practitioners time to go for post-graduate work, for holidays and generally to cut down the hours of duty so that their life expectancy will be increased.

All of which is respectfully submitted.

A. Hollenberg,  
Chairman.

### **Report of the Committee on Constitution and By-laws**

*To the President and Executive of*

*The Manitoba Medical Association:*

The revision of the Constitution of the Manitoba Medical Association, as ordered by the Executive, was duly drafted and accepted at the Annual Meeting of the Association in September, 1944. The changes that were made aimed to emphasize the general social relations of the medical profession and to make the procedure of the organization more simple and direct.

Copies of the approved revision will be available to the members at this Meeting.

Since the revision was completed, the attention of the committee has been called to the fact that the M.M.A. representative to the C.M.A. Executive is not of necessity a member of the M.M.A. Executive. This should be corrected by a further revision.

Respecting changes in the Constitution of the Canadian Medical Association, the Committee on Constitution and By-laws of the C.M.A. submitted for consideration at the meeting in 1944 certain proposals for broadening representation on

Council and, after a year's consideration, the following proposals were recommended by the Committee at the Annual Meeting of the C.M.A. in Montreal in June, 1945, for decision in 1946:

- (a) THAT each of the Universities of Canada which had a medical school be represented on General Council by the Dean of the Medical School.
- (b) THAT affiliated societies which were medical under stipulated circumstances be represented on General Council, each by one member. (While the wording of this revision is not entirely clear your committee interprets it to mean affiliated medical societies only.)
- (c) THAT provision be made for undergraduate membership in the C.M.A.
- (d) THAT there should be added to the Executive Committee three Members at Large elected from the General Council.

Your committee holds the view that too great enlargement of Council carries the risk of neutralizing its special outlook and that, if representation of special groups appears advisable, it should be, as far as feasible, reciprocal, that is the special groups should admit a designated representative of the C.M.A. to an equivalent position in its organization.

Respectfully submitted.

F. D. McKenty,  
Chairman.

### **Report of Committee on Public Health**

*To the President and Executive of*

*The Manitoba Medical Association:*

Despite the lack of Public Health personnel and practicing medical men, the health of the public generally in the Province has continued to remain at a satisfactorily high level. There has been no great increase in communicable disease although diphtheria still remains a greater problem than it should with our known means of prevention. Venereal Disease has shown an increase during the past year and this increase will likely be accelerated for at least the period of demobilization and probably for some little time thereafter. Increased efforts are being made to try and locate and bring under treatment sources of infection and to bring in for examination contacts of known cases. Penicillin is being used for the treatment of both gonorrhoea and early syphilis in the Venereal Disease clinic at the St. Boniface Hospital, and is proving very satisfactory. It is too soon to say, of course, just how permanent the results of treatment of syphilis by penicillin will be, and several years will probably elapse before we can be assured that apparent cures, after the course of treatment, are permanent.

During the past year the City of Winnipeg appointed Doctor R. P. Cadham as Assistant Medical Director of the City Health Department. Doctor Cadham is presently in the Royal Canadian Air Force but it is hoped that he will be released for duty with the City Department shortly. The City has also provided in its establishment for the appointment of a Sanitary Engineer and it is expected that this appointment will be made within the next few months.

There have been some changes in the personnel of the Provincial Department of Health. Doctor C. E. Mather, Director of Local Health Services, resigned to take a position with the C.N.R. Medical Services, and his position has been filled by Doctor Paul L'Heureux, formerly Medical Director of the St. Boniface Health Unit. Doctor Elizabeth Lautsch has come on the staff as Director of Maternal and Child Hygiene and has established a series of Maternal and Child Clinics throughout the unorganized districts of the Province.

At the last session of the Legislature the Health Services Act was passed making provision for the establishment of Full-time Health Units to cover all the province, as well as diagnostic facilities and assistance to local rural areas in obtaining pre-paid medical services. Since the Act came into

force, four Full-time Units, consisting of seventeen rural municipalities, have been established but have not as yet been brought into operation due to the lack of personnel. Fourteen other municipalities have requested the formation of Health Units. The presently operated health units of St. Boniface, and St. James-St. Vital, will come under the provisions of the new legislation almost immediately. If personnel was available it would appear as if the whole of the Province might be covered by Full-time Health Units by the Fall of 1947, and this is the present goal of the Department of Health and Public Welfare.

One district is preparing to vote on the erection of a completely modern thirty-bed hospital, and if the vote carries, erection of the hospital may start this Fall. Petitions are in from another district to have a board set up to prepare plans for a forty-bed hospital to replace the present building in use. Four other districts are in the course of circulating petitions to have hospital districts established.

One of the unique features of the Health Services Act is the method of control. This is through the Advisory Commission consisting of three members nominated by the Manitoba Branch of the Canadian Medical Association, one member of Manitoba, three members nominated by the Executive of the Union of Manitoba Municipalities, three members appointed by the Lieutenant-Governor of the Province, and the Deputy Minister of Health, who is an ex officio member of the Commission. This means that at all times there will be at least five members of the Commission who are medical persons. Under the provisions of the legislation no regulations to establish the services provided by the Act can have any force or effect until they have been approved by the Commission, and by this it will be seen that the Commission as appointed actually determines the manner in which the provisions of the legislation shall be carried out. The Commission has already had an organization meeting and committees have been named to prepare regulations in respect to the various sections of the Act.

The Tuberculosis Control Commission has been organized and is ready to go forward with its work as soon as a Director of Tuberculosis Control can be secured. Despite the shortage of staff the Sanatorium Board of Manitoba continued to carry on the travelling clinic work, as well as conducting many mass surveys of persons in industry and in communities. Altogether during the past year some 59,420 chest plates were taken, and of these 16,543 were done by the Tuberculosis Control Division of the City of Winnipeg Health Department in co-operation with the Board.

The first session of the Dominion-Provincial Conference which was held at Ottawa commencing August 6th, 1945, indicates that within the next few years there will be a material change in the present method of payment for medical and allied services. If all the proposals of the Federal Government in respect to health are implemented throughout the provinces, every person in Canada, regardless of his residence or his economic status will be provided with complete health services.

All of which is respectfully submitted.

F. W. Jackson,  
Chairman.

## Report of Committee on Maternal Welfare

To the President and Executive of

The Manitoba Medical Association:

For Obstetrical purposes, the vital statistics for 1944 were as follows:

1. Total number of live births .....	16,106
2. Total number of still births .....	334
3. Total number of neo-natal deaths .....	294
(i.e. newborns under 2 weeks of age)	
4. (a) Total number of maternal deaths .....	49
(of this number 17 were due to abortion)	
(b) Associate cases .....	3

This is approximately a maternal mortality of less than 3 per 1,000 live births, which is not as good a showing as last year.

Abortions, as already mentioned, accounted for .....	17
Haemorrhage .....	5
Infection .....	8
Toxemia .....	11
Other .....	8

There were no autopsy records in 33 of the maternal deaths. The forms submitted by medical men were, as a rule, quite properly filled out. In some instances, however, essential details were left out.

In this connection, perhaps a more strenuous effort might secure autopsies in a larger number of cases. May it not be even worthwhile to secure legislation to make it compulsory to have autopsies in all cases of deaths associated with pregnancy?

In connection with the unpleasant episode in one of the hospitals re identification of the newborn, it might be worthwhile to have a committee struck to bring in a recommendation to have a uniform system of identification for all hospitals, small and large, throughout the province. This may be referred to the Manitoba Hospital Association for action.

During the past year there was one communication re training of midwives from the Federal Department of Health, forwarded to us by Dr. F. G. McGuinness, Chairman of the Committee on Maternal Welfare of the Canadian Medical Association.

The Chairman of the Manitoba Division thought he was expressing the view of the bulk of the profession when he wrote as not being in favor of increasing the number of these midwives, even if they were given some training.

One other point we would like to draw to your attention. We believe it is time for a "revision" of the "baby and mother" books that are supplied by the Dominion and Provincial Governments. The laity appreciate very much the ones we now have, but we think we are justified to ask for a revision to bring them up-to-date.

We would like to take this opportunity to express our appreciation to Miss L. E. Stewart of the Department of Vital Statistics for material she so kindly provided.

All of which is respectfully submitted.

S. Kobrinsky,  
Chairman.

## Committee on Archives

To the President and Executive of

The Manitoba Medical Association:

The Committee on Archives begs to report:

1. Few, if any, additions have been made to the archives of this Association.
2. Returning war veterans are requested to present to the archives war diaries of Manitoba units, captured surgical instruments or objects of interest. It must not be forgotten that what seems the commonplace of today may be of great interest to a later generation. The Winnipeg General Hospital once possessed and used a Lister spray, but it was long ago discarded as useless and no trace of it can now be found.

Respectfully submitted.

Ross Mitchell,  
Chairman.

## Report of Committee on Nutrition

To the President and Executive of

The Manitoba Medical Association:

There is nothing to report on behalf of the Committee on Nutrition since the last Annual Meeting.

Respectfully submitted.

Harold Popham,  
Chairman.

## Report of Workmen's Compensation Board Fee Schedule Committee

To the President and Executive of

The Manitoba Medical Association:

Minutes of a meeting held August 30th, 1945, of Dr. Gunn's Committee re fees, with Dr. D. J. Fraser and Mr. N. Fletcher of the Workmen's Compensation Board.

Present:

Dr. J. A. Gunn, Chairman  
Dr. P. H. McNulty  
Dr. W. E. Campbell  
Dr. D. J. Fraser  
Mr. N. Fletcher

Dr. Gunn read a letter from Dr. A. Hollenberg re treatment for medical conditions existing in surgical cases. The letter was referred to the Board with a request that the general principle of treatment of medical conditions affecting recovery be reconsidered by the Board.

A motion of the Manitoba Medical Association Executive of February, 1944, concerning reinstatement of the \$2.00 fee for reports was forwarded to the Board with a recommendation for their favourable consideration.

It was recommended that there should be a general revision of medical fees to bring them in line with the higher remuneration being received by all classes and in line with increased costs of living which affect members of the medical profession the same as the rest of the public. It was pointed out that the fee for hernia has always been too low and it was recommended that the fee should be \$75.00—\$100.00 for single and double hernia respectively.

A letter from Dr. Abbott re payment for physiotherapy was read. The Board's ruling is "that physiotherapy will be paid for only in advance" as stated in the published schedule of fees.

The question of the Medical Board of Reference was discussed. The meeting was of the opinion that continuity of service of the Chairman and Vice-Chairman is valuable and that a term of four years is reasonable; that the holders of these positions should be eligible for re-election and that the election of Chairman and Vice-Chairman should be alternating, one of these being elected every two years to hold office for four years; also that the panel of additional members should be kept up-to-date by the Executive at all times.

Respectfully submitted.

W. E. Campbell,  
Secretary.

## Report of Committee on Industrial Medicine

To the President and Executive of

The Manitoba Medical Association:

A meeting of physicians interested in the practice of Industrial Medicine was held April 25th, 1945. To stimulate the establishment of part time medical services in Manitoba it was decided attempts should be made to develop for industry a practical outline of the services they might expect from Plant Medical Officers.

It was also decided that the Winnipeg Medical Society should be approached regarding the establishment of an Industrial Medical Section in the Society.

Further action on both these points has been held in abeyance during the summer months.

Respectfully submitted.

Hugh Malcolmson,  
Chairman.

## Committee on Historical Medicine and Necrology

To the President and Executive of

The Manitoba Medical Association:

Your Committee begs to report:

Death continues to lay its hand on Manitoba physicians. The following have passed away between July, 1944 and September, 1945:

Capt. Harry Marantz, R.C.A.M.C., August 15, 1944.  
Henry Havelock Chown, October 12, 1944.  
R. E. Davis, December 10, 1944.  
Lt. Col. A. W. S. Hay, R.C.A.M.C., December 31, 1944.  
Col. R. M. Simpson, February 2, 1945.  
Robert C. E. Magee, February 13, 1945.  
Edward C. Barnes, February 19, 1945.  
Capt. David Stewart Noble, R.C.A.M.C., April 22, 1945.  
Johann Mario Sigvaldson, June 3, 1945.  
Andrew Pritchard MacKinnon, June 14, 1945.  
Abraham Louis Shubin, August 13, 1945.  
John Henry Richard Bond, August 22, 1945.  
Narcisse Albert Laurendeau, September 4, 1945.  
Capt. A. D. McFadden, R.C.A.M.C.  
Capt. Harry Dickson, R.C.A.M.C.

Dr. H. H. Chown was President of the Canadian Medical Association, and for many years Dean of Manitoba Medical College.

Capt. Marantz, Lt. Col. Hay, Capt. Dickson, Capt. McFadden and Capt. Stewart Noble were war casualties.

Col. R. M. Simpson was one of the earliest graduates of our medical school, president of the Manitoba Sanatorium Board and for many years Chairman of the Board of Health.

Dr. Barnes was formerly superintendent of the Selkirk Mental Hospital and a first vice-president of Manitoba Medical Association.

Dr. A. P. MacKinnon was a former president of Winnipeg Medical Society.

Dr. N. A. Laurendeau was for two years Mayor of St. Boniface.

To the relatives and friends of our departed brethren we offer our deep sympathy.

Respectfully submitted.

Ross Mitchell,  
Chairman.

## Committee on Credentials and Ethics

To the President and Executive of

The Manitoba Medical Association:

As no problems have been submitted to this Committee during the year, there is nothing to report.

Respectfully submitted.

A. F. Menzies,  
Chairman.

## Committee on Pharmacy Report

To the President and Executive of

The Manitoba Medical Association:

This Committee considered and commented upon material supplied by the main Committee in Toronto. The work in hand was the preparation of a Formulary for use in the National Health Scheme. Our work has been completed.

J. C. Hossack,  
Chairman.

# "PHENO-ACTIVE"

C.C.T. No. 213 "Frosst"

FOR THE TREATMENT OF  
**CONSTIPATION**



## IDEAL FOR TRAVELLING



You can safely recommend Pheno-Active to patients who experience constipation when travelling or on holidays. The tube of 25 tablets conveniently fits into a vest pocket or handbag.

Pheno-Active . . . the tiny bedtime laxative, restores bowel regularity in cases of mild or occasional constipation. Its principal ingredient, Phenolphthalein, is mild, non-toxic, tasteless and little absorbed. Combined with small amounts of Aloin and Ipecac, it acts on the large intestine and results in a soft formed stool. Belladonna is present in the formula to relieve any spastic condition.

## DOSAGE

One or two tablets at night is usually sufficient. In more obstinate cases, one tablet after each meal; and then reduced to one morning and night.

## MODES OF ISSUE

Tubes of 25, Bottles of 100. Also dispensing bottles of 500 tablets.

**Charles E. Frosst & Co.**  
MONTREAL CANADA

The Canadian Mark of Quality Pharmaceuticals Since 1899

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WHERE QUALITY AND PRICE ARE EQUAL OR BETTER, PRESCRIBE CANADIAN PRODUCTS

## Manitoba Medical Service

### Musings

An association with the practice of medicine for nearly fifty years, and the closure of that association, entitles one to retrospection, and expression of views which, if not sound or acceptable, have at least had time to mature, and may induce a valuable controversy.

As a house surgeon in a Dublin hospital I had the privilege of listening to the words of wisdom uttered by my elders. A discussion between two distinguished surgeons Sir T——— and Sir Wm. ———— stayed with me because of the conclusion they reached, that a cabinet maker would be ashamed to turn out the kind of work that a surgeon did.

I have seen surgery pass through three epochs. In the last years of the 19th century, major and especially abdominal surgery was attended by so much risk for the patient that judgment was paramount, with two important questions to be faced, can the disability from which the patient suffers be removed or relieved, and is the likelihood of recovery proportionate to the risk.

The next stage was a tendency toward exaltation of technical skill, at the expense of judgment, especially when surgery entailed fewer risks. The doctor who could remove an appendix in thirty seconds less than his rivals was a wonderful surgeon; he was or might be nothing of the kind; he was a skilful technician, but so is a watchmaker, a diamond cutter, a radio mechanic or even a Chinese hospital attendant who, we are told, after assisting at an appendectomy half a dozen times can perform a perfect operation, provided the diagnosis has already been made, and the appendix is where it ought to be. The journalist and the novelist dramatized this phase by writing of the surgeon's "wonderful hands", but made no reference to his head. I cannot recall similar praise of a watchmaker whose work is so fine that he does much of it under a magnifying glass.

We have now reached the third period, and one is inclined to ask how much better off is the patient. Technical skill cannot be improved beyond a certain stage. Major surgery has become safe, very safe, as shown by the fact that in spite of the number of operations being done, the age outlook is steadily improving. A new factor has now come, the machine, whether it be the X-ray, the pathologist's microscope, etc., the electrocardiograph, B.M. machine and so on. To what extent do they influence judgment, to what extent do they supplant it? The machine seems so positive, so scientific, and the patient's descrip-

tions of his or her sufferings while very positive, are frequently misleading and anything but scientific. The surgeon who has to spend so much of a busy day at the operating table, at that period of the twenty-four hours when his faculties are at their highest pitch, has later to call on those faculties to pass judgment on many difficult problems at the bedside or in the office. Is it any wonder that mentally and physically tired as he is, the positive findings of the machine look like the guiding needle of a compass?

It would appear, therefore, that a surgeon's activities and services consist of three factors, judgment, technical skill, ancillary services usually performed by an assistant, but used as an aid to the surgeon's judgment. If an exploratory operation is performed then judgment is thereby acknowledged to be at fault, for you cannot judge when you have no facts to guide you. Technical skill may vary depending on the simplicity or difficulties of the operation, and is always improved by experience. Ancillary services may be helpful or, by shaking the surgeon's judgment, harmful. Dr. Alvarez, in a recent and very interesting book, has shown that the abnormality found by a diagnostic aid, is frequently in no way responsible for the illness and that the removal of that abnormality will not cure the patient.

The size of the bill is an aftermath, for no surgeon by the operating table ever thinks of what the reward will be. Prince or pauper get the same care. I would like some surgeon or surgeons to carry my musings a step forward and put a relative value, points if you like, on the different factors which go to the preparation for and performance of an operation. There are, of course, other factors the most important of which are the time and cost needed to acquire a medical education, and the earlier years when for lack of patients a doctor is unable to exercise his full earning powers. If carried as an overhead the amount to be written off against each operation would probably be very small. Office, equipment and other overhead can be easily estimated by an accountant.

For years the doctor and his profession have been sacrosanct; but that age is passing; he is now being criticised, often unjustly, but criticised nevertheless. Democracy will no longer accept even the mild autocracy of medicine, and people want to know what the doctor is doing and why. If we give them carefully prepared information on our activities, they will be the less prepared to pay attention to the outpourings of the Journalist who does not earn his livelihood by being restrained in his use of adjectives. If we can

analyse the factors which enter into the high cost of major surgery, and their value, then we shall have put an end to much of the criticism levelled at the profession by the public. Even though the public is fickle their understanding of our problems will help to get a sympathetic hearing from them during the evolution that is upon us.

E. S. M.

### Manitoba Medical Service

The anticipated decrease in utilization of medical services in June and July did not take place, with the result that the number of reports, and volume of expenses are both very high. The Manitoba Hospital Service Association gives the same unusual picture, a very marked increase in hospitalization during June, July and August over May. It would appear as if the introduction of Manitoba Medical Service had aggravated the shortage of beds.

In the last issue I asked for reports or estimates as to whether or not doctors were being paid for services to people who in the past had gone to out-patient departments or into public wards. Up to date this office has received no reply, from which one would infer that doctors are no better off in that respect. To tell the truth I don't believe it. I see the addresses of people who are going to leading physicians, and also know the financial status of most of the members of large groups, which is my reason for disbelieving it.

People are being enrolled who have no right to be in the service. They ignore two questions on their application card—"None of the above named persons need care excepting . . .", and "Whose attending physician is . . .". Within a very short time after acceptance, a report comes in showing that major medical or surgical services have been supplied. We have no restrictions on pre-existing ailments; such a clause causes argument and recriminations in many plans, for people often have indefinite disabilities and are unaware of the serious significance of them until they have had an opportunity to consult a doctor. However we are determined to put a check on the individual who is well aware that he needs a great deal of care, and joins for the purpose of having some one else pay his bills. Where the applicant reports pre-existing ailments, we get in touch with his doctor, and obtain a history; doctors frequently

advise us against acceptance. We can accept, reject, or accept excluding treatment of a particular disease and its complications. On learning that a diabetic boy took his insulin regularly, and observed his dietary rules, we accepted him excluding diabetes. If a patient comes to a physician within two or three weeks of acceptance we get in touch with the doctor, but otherwise we pass accounts; yet the doctor may be aware that the member has been making the rounds of doctors' offices for years with the same complaint.

This state of affairs can only be corrected through your co-operation. If you are suspicious of the good faith of a patient, please let us know and we will carry out the necessary investigations. The member gives us authority to obtain any details needed from his or her doctor. We hope to be able to assist you by stamping the date of acceptance on all cards issued to members.

Dr. R. Smith and Dr. Turner paid us a three day visit in August. Dr. Smith is the medical supervisor of the Hollinger Medical Service, which includes several smaller mines, and has been in operation since 1937; Dr. Turner occupies the same position in the Noranda Mine. Total membership including dependents is about 30,000; it is regarded in Canada as a very efficient plan. Though our plan greatly differs from it, the doctors were much interested in our administrative methods, and went very thoroughly into details. They pay 75% on every service in a fee scale which is in some details lower than the Ontario scale, and much lower than ours. The average doctor's income is \$7,000.00 a year with a low of \$300.00 and a high of \$20,000.00. There is additional revenue from Workmen's Compensation Board cases, retaining fees, etc. As there do not appear to be specialists in the area, certain cases have to be sent to Toronto. Control is vested in a board of directors, with equal representation from employees and doctors.

Manitoba Medical Service membership as at July 31st. was 19,056. Approved claims for July amounted to \$23,471.00. \$14,996.00 were paid out, being 63.9% of claims.

Some doctors have the idea all their payments amount to 63.9%. This is not so, for instance the high account received was \$1,551.00, he received \$768.60 or 49.5%. The low account for \$4.00 was paid 100%. Another instance: an account of \$422.25 was paid \$347.12 or 82.2%.

E. S. Moorhead, M.B., Medical Director.



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<sup>1</sup> Biskind, G. R.: Proc. Soc. Exper. Biol. & Med. 43:259, 1940.  
Burrill, M. W. and Greene, R. R.: Endo. 31:73, 1942.

<sup>2</sup> Lissner, H. and Curtis, L. E.: J. Clin. Endo. 3:389, 1943.

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1344 Connecticut Avenue, Washington 25, D.C.  
September 4, 1945.

The Editor,  
The Manitoba Medical Review,  
102 Medical Arts Bldg.,  
Winnipeg, Canada.

Dear Sir:

May I ask you to be good enough to help us by bringing the following to the notice of the members of your Association?

The Chinese Government has requested UNRRA to provide, as soon as possible, some 200 field personnel of the following categories to strengthen the available Chinese personnel. Such personnel will be required to head the respective services in hospitals of 100 or 250 beds, which will be established in areas recently liberated from the Japanese.

General Surgeons, Orthopedic Surgeons, Genito-Urinary Surgeons, Gynecologists and Obstetricians, General Physicians, Dermatologists and Syphilologists, Ophthalmologists, Otolaryngologists, Radiologists, Dentists, Pediatricians, Laboratory Technicians, X-ray Technicians, Sanitary Engineers, Public Health Engineers, Public Health Nurses, Clinical Nurses.

General practitioners with some specialist experience will be acceptable. Candidates should be under 55 years of age and in good physical condition.

Will those interested please write to me at UNRRA, 1344 Connecticut Avenue, N.W., Washington 25, D.C.

Yours sincerely,  
Szeming Sze, M.D.,  
Chief, Far East Section Health Division.

◆  
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## Department of Health and Public Welfare

### Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1945		1944		TOTALS	
	July 15 to Aug. 11	June 17 to July 14	July 16 to Aug. 12	June 18 to July 15	Jan. 1 to Aug. 11, '45	Jan. 1 to Aug. 12, '44
Anterior Poliomyelitis .....	2	1	13	1	10	18
Chickenpox .....	78	242	49	147	1613	1591
Diphtheria .....	15	12	18	27	179	126
Diphtheria Carriers .....	---	---	1	1	23	20
Dysentery—Amoebic .....	---	---	---	---	---	---
Dysentery—Bacillary .....	1	---	2	2	5	7
Erysipelas .....	1	3	1	4	34	48
Encephalitis .....	1	1	1	1	4	6
Influenza .....	4	2	2	4	110	202
Measles .....	18	53	86	332	460	5094
Measles—German .....	---	5	1	9	33	234
Meningococcal Meningitis .....	1	---	---	---	11	17
Mumps .....	50	133	22	42	1178	1440
Ophthalmia Neonatorum .....	---	---	1	---	---	1
Pneumonia—Lobar .....	---	4	3	12	65	143
Puerperal Fever .....	---	---	1	---	---	6
Scarlet Fever .....	31	40	57	92	470	1786
Septic Sore Throat .....	---	2	---	---	14	21
Smallpox .....	---	---	---	---	---	---
Tetanus .....	1	---	---	---	1	1
Trachoma .....	---	---	---	---	---	---
Tuberculosis .....	58	61	57	61	379	443
Typhoid Fever .....	3	1	---	---	28	41
Typhoid Paratyphoid .....	---	2	---	---	5	---
Typhoid Carriers .....	---	---	---	1	2	1
Undulant Fever .....	1	1	2	---	9	6
Whooping Cough .....	6	4	46	26	203	268
Gonorrhoea .....	206	169	149	111	1229	1073
Syphilis .....	43	32	62	53	356	411
Actinomycosis .....	---	---	---	---	---	2

DISEASES (white cases only)	*726,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,000 Minnesota	*641,925 North Dakota
Actinomycosis .....	---	---	---	---	---
Anterior Poliomyelitis .....	2	30	---	3	1
Chickenpox .....	78	314	53	---	16
Diphtheria .....	15	16	3	26	9
Diphtheria Carriers .....	---	---	---	---	---
Dysentery—Amoebic .....	---	---	---	2	---
Dysentery—Bacillary .....	1	---	---	---	---
Encephalitis, Epidemica .....	1	---	1	---	---
Erysipelas .....	1	3	---	---	---
Influenza .....	4	36	---	---	14
Measles .....	18	308	30	13	3
Measles—German .....	---	30	4	---	---
Meningococcal Meningitis .....	1	2	---	3	---
Mumps .....	50	132	23	---	---
Ophthalmia Neonatorum .....	---	---	---	---	---
Puerperal Fever .....	---	---	---	---	---
Scarlet Fever .....	31	138	7	83	16
Septic Sore Throat .....	---	3	---	---	2
Smallpox .....	---	---	---	---	---
Trachoma .....	---	---	---	---	---
Tetanus .....	1	---	---	---	---
Tuberculosis .....	48	197	14	26	16
Tularemia .....	---	---	---	---	---
Typhoid Fever .....	---	3	9	---	2
Typhoid Para-Typhoid .....	---	2	---	---	---
Undulant Fever .....	1	3	---	14	---
Whooping Cough .....	6	94	5	52	8
Gonorrhoea .....	206	642	---	---	68
Syphilis .....	43	290	---	---	10

V.D. problem will probably become more acute. Our motto should be "Every case under adequate treatment, every contact found and examined." Prenatal blood testing and premarital examinations are very worth while.

#### Deaths from Communicable Disease

June, 1945

**Urban**—Cancer, 56; Influenza, 1; Pneumonia Lobar, 4; Pneumonia (other forms), 7; Scarlet Fever, 1; Syphilis, 4; Tuberculosis, 5; Paratyphoid Fever, 1; Septicemia, 1; Disease of Skin, 1; Septic Sore Throat, 1. Other deaths under 1 year, 28. Other deaths over 1 year, 180. Stillbirths, 18. Total, 308.

**Rural**—Cancer, 18; Diphtheria, 1; Influenza, 3; Pneumonia Lobar, 1; Pneumonia (other forms), 6; Poliomyelitis, 1; Puerperal Septicaemia, 1; Syphilis, 1; Tuberculosis, 5; Disease of Skin, 1; Dysentery, 1. Other deaths under 1 year, 21. Other deaths over 1 year, 174. Stillbirths, 7. Total, 241.

**Indians**—Pneumonia (other forms), 2; Tuberculosis, 1. Other deaths under 1 year, 0. Other deaths over 1 year, 1. Stillbirths, 0. Total, 4.

#### Deaths from Communicable Disease

July, 1945

**Urban**—Cancer, 74; Pneumonia (other forms), 8; Tuberculosis, 5; Syphilis, 5; Pneumonia Lobar, 2; Hodgkin's Disease, 2; Diphtheria, 1. Other deaths under 1 year, 15. Other deaths over 1 year, 189. Stillbirths, 9. Total, 310.

**Rural**—Cancer, 43; Pneumonia (other forms), 15; Tuberculosis, 12; Pneumonia Lobar, 3; Syphilis, 3; Influenza, 2; Lethargic Encephalitis, 1; Typhoid Fever, 1; Whooping Cough, 1; Septic Sore Throat, 1; Dysentery, 1. Other deaths under 1 year, 35. Other deaths over 1 year, 215. Stillbirths, 13. Total, 346.

**Indians**—Tuberculosis, 17; Pneumonia (other forms), 14; Influenza, 6; Whooping Cough, 2; Measles, 1; Pneumonia Lobar, 1. Other deaths under 1 year, 15. Other deaths over 1 year, 16. Stillbirths, 1. Total, 73.

**Diphtheria** is still too prevalent. The infection is widespread and cases may be prevented chiefly through immunization of all non-immunes.

**Poliomyelitis and Encephalitis** have not been a serious problem this year and their season is almost over. We have been fortunate.

**Gonorrhoea** shows some increase—**Syphilis** a very slight decrease. With the return of our Armed Forces the

## Preventative Dental Services an Urgent Need

Dr. A. E. Proctor

Canadian Foundation for Preventive Dentistry

### Dental Illiteracy

So far as the dental health of children and youth is concerned, the figures on the terrible array of dental defects found among drafted men present ample evidence that our people are dentally illiterate and seemingly do not care if they are. Any research that presents any possible means of preventing these dental ravages should be encouraged and its results broadcast.

(Editorial, Journal of School Health, March, 1945.)

Generally speaking, dental care has been the orphan of public health services. Most people visit a dentist (sooner or later) for necessary curative work. But preventive services have been few and far between. There is a chronic shortage of qualified dentists, and so far there is no organized system of prepayment for dental care.

In Manitoba, travelling dental clinics have served some of the rural communities most in need of dental care. These clinics were organized through the initiative of the dental profession itself. Today they are conducted by the Canadian Foundation for Preventive Dentistry, organized in Manitoba with headquarters in Winnipeg.

Clinics may be sponsored by the municipal council, the school board, or by some responsible organization such as the Women's Institute or the Manitoba Federation of Agriculture and Co-operation. The sponsoring body (or bodies) must be prepared to pay a minimum of \$20 for each operating day, which comes to about 60% of the total cost of the clinic. The remaining cost is met by grants from the Manitoba Dental Association and the Department of Health and Public Welfare. The community is also expected to supply a room and certain facilities for the clinic, room and board for the dentist, and other details.

When all arrangements have been made, the clinic is open to all public school pupils in grades 1 to 8, with the addition of pre-school children wherever possible. Adults will not be treated at the clinic, and pupils in higher grades are eligible only in exceptional cases, and only after special arrangements have been made.

The clinics are conducted by a licensed registered dentist and a public health nurse. Every effort is made to meet modern standards of diagnosis and treatment. The services of the clinic include thorough dental examinations, extractions, fillings, prophylaxis, and certain treatments. Special cases are referred to regular dentists for treatment. As yet, it has not been possible to include X-ray examinations in the routine work

of the clinics.

The history of these clinics is interesting. Back in 1929 and 1930, Manitoba dentists with the co-operation of the Department of Health and Public Welfare carried out a Mouth Health Campaign. This campaign included free clinics for pre-school and public school children. These clinics were made free in order to demonstrate to local authorities and to the public the great need which existed for preventive dental work.

The campaign was successful, and during the next two years local clinics were organized with the local authorities paying a certain share of the cost per day. The official sponsorship came from the Canadian Dental Hygiene Council, the Manitoba Dental Association, and the Department of Health and Public Welfare. Arrangements for clinics were made with towns, municipalities, individual school districts, or public-spirited organizations.

In 1932, the Canadian Foundation for Preventive Dentistry was organized to carry on the clinics. The Foundation also sponsors a general campaign for dental health, using the educational media of press, radio and bulletins. Among its future objectives is the supervision of research on dental health, and the publication of the findings so that they may be made available to the public. At present its work is limited to the clinics.

"The function of the Foundation," states the official Aims and Purposes, "is to show the public and officials the need of any particular clinic, assist them in building the necessary funds to carry on the work, survey the area, provide and mark the necessary charts, and conduct the follow-up work and supervision of all details of repeat clinics."

Since 1935, the Foundation has conducted about 50 clinics a year, thus serving an average of 3,000 children per annum. The peak year was in 1938, when 4,500 children were examined, and nearly 10,000 operations (fillings and extractions) were made.

These clinics have been conducted mainly in the outlying parts of the province, far removed from dental service. The value of preventing oral disease has been conclusively proven both from the standpoint of the child and from that of the teachers, who note a greater attention to and interest in school work. Ill health causes "repeaters" and re-education is a costly process.

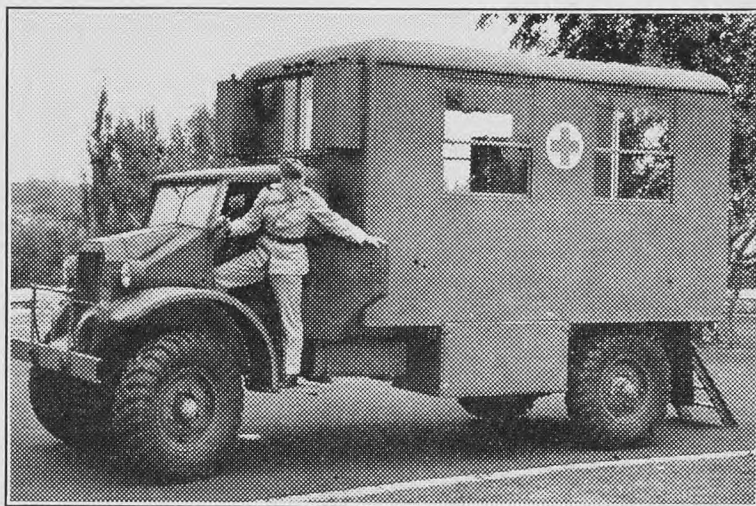
The clinics and surveys conducted by the Foundation have revealed a tremendous need for

preventive dentistry. A survey of Winnipeg Normal School students conducted in 1943 shows that of 265 students examined, 253 required dentistry. The minimum dentistry required by the 253 consisted of: 45 extractions, 200 fillings, and 162 prophylactic treatments. These students are fairly typical of the people of Manitoba.

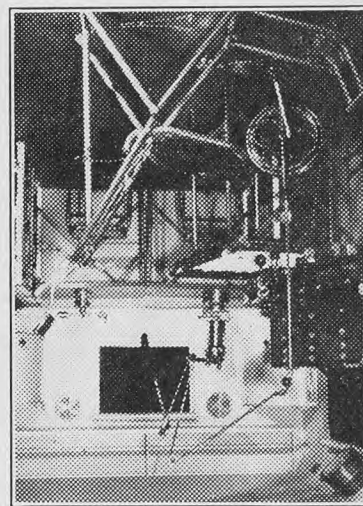
A recent survey has been made of dental service needs in the Porcupine district of North-

there are only about 250 dentists in Manitoba, and many districts have no dentist whatever. Facilities in our present dental colleges must be greatly expanded, and students encouraged to enter dentistry by means of scholarships, more attractive conditions in the profession, and assistance to rural communities in provision of adequate dental facilities.

The other great need is education. People



1. Mobile clinic used by the Canadian Dental Corps. It is hoped that some of these may be available for use in rural Manitoba after the war.



2. Interior of the mobile clinic. Standard dental chair would replace army equipment for civilian use.

ern Ontario. This exhaustive survey concerned all children up to 14 years of age. Not only did it reveal great needs to be met, it also investigated methods of meeting the needs. For instance, the survey made a thorough examination of all children by the standard methods, noting all defects needing correction. Then the same children were given an X-ray examination, which revealed an average of slightly more than one additional defect per child needing correction.

The conclusion of the Porcupine survey was that, in addition of other services, every child should have a routine X-ray examination once a year. While the cost of X-ray services is high, the community would be more than repaid in prevention of disease and early detection of dental defects.

Thus we see that an urgent post-war need is dental clinics for every community, equipped with the best modern equipment for treatment and diagnosis. An even more urgent need, however, is that of more dentists to operate clinics and to establish private practice in rural communities. At present, there are not enough dentists to go around. Including those now in the armed forces,

will not take proper advantage of a preventive dental service until they understand its value, and their own responsibility for regular examinations and day-to-day care. The Porcupine survey in its recommendations assumed "that a definite and adequate educational program will accompany the institution of dental treatment."

Future planning of dental services in Manitoba should attempt to meet these needs. The clinics might be extended to cover all rural districts in need of preventive services. It is hoped that the Canadian Foundation for Preventive Dentistry will be able to obtain a number of the mobile clinics now in use by the Canadian Dental Corps. These are compact dental offices on wheels, complete with all necessary equipment. Several of these clinics could quickly reach the most outlying districts of Manitoba with efficient service. Finally, the "Medical Care" provisions of the Manitoba Health Plan should enable municipalities in full-time Health Units to make contracts with dentists for prepaid dental care, including preventive services. This is Manitoba's opportunity to develop "sound teeth in a sound body" for all our future citizens.



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- Each capsule contains 50 milligrams of mixed tocopherols, equivalent in vitamin E activity to 30 milligrams of a-tocopherol.

Tocopherex contains vitamin E derived from vegetable oils by molecular distillation, in a form more concentrated, more stable and more economical than wheat germ oil.

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## **VIOPHATE - D**



### **FOR INCREASED CALCIUM REQUIREMENTS**

- Each capsule of Viophate—D contains 4.5 grains Dicalcium Phosphate, 3 grains Calcium Gluconate and 330 units of Vitamin D. The capsules are tasteless, and contain no sugar or flavouring. Where wafers are preferred, Viophate—D Tablets are available, pleasantly flavoured with wintergreen.

One tablet is equivalent to two capsules.

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Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

\*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, *Am. J. Dis. Child.* 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

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